Mississauga Halton
LOCAL HEALTH INTEGRATION NETWORK

LOCAL D'INTÉGRATION DES SERVICES DE SANTÉ
de Mississauga Halton

Integrated Health Service Plan

Mapping Out Three Years of
Better Health Care 2007-2010

Ontario

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In Mississauga Halton and across Ontario, Local Health Integration Networks (LHIN) have developed Integrated Health Service Plans (IHSP) as their first major initiative. The IHSP is a three-year strategic plan that is consistent with provincial strategic directions and includes integration priorities and action plans for creating an accessible, coordinated and integrated local health system. The IHSP was developed in concert with the community, local health service providers, key health partners and establishes the foundation for future LHIN planning initiatives.

Mississauga Halton LHIN Board of Directors

The Mississauga Halton Local Health Integration Network (LHIN) is a body created by the Local Health System Integration Act, 2006 and it is governed by a nine-member Board of Directors. The members of the Board of Directors live in the communities we serve (south Etobicoke, Mississauga, Oakville, Milton and Halton Hills) and they are appointed by Lieutenant-Governor Order-in-Council, based on their skills and experience. The Board provides strategic leadership and fiduciary stewardship for the Mississauga Halton LHIN, on behalf of the current and future residents of our communities and the Ontario Ministry of Health and Long-Term Care.

Our founding LHIN Board:

John Magill
Chair

Norman Murray
Vice Chair

Brij Chadda

Caesar Cheng

Tim Costigan

Dr. Elliot Halparin

Jane McCarthy

Edward R. Morris

Enola D. Stoyle

Full profiles of our Board members can be viewed at **www.lhins.on.ca**

ACKNOWLEDGEMENT

The Board of the Mississauga Halton Local Health Integration Network (LHIN) would like to extend our sincere thanks to over 3,000 people from across our communities, both public and health service providers, who have helped shape our first Integrated Health Service Plan.

We would also like to recognize the important role that members of the Integration Advisory Group played in guiding the community engagement process and shaping input from our communities to create this report.

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Lastly, the Board would like to express its sincere appreciation to our LHIN staff team and the PricewaterhouseCoopers team led by Barbara Pitts for their dedication and tenacity in completing this plan.

The collective contributions of everyone involved have resulted in the first Integrated Health Service Plan; a plan which is sound, focused on our collective vision and provides a strong directional foundation for moving forward together.

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1

Provincial Context – Transforming Health Care

A health system that helps people stay healthy, delivers good care to them when they get sick and will be there for their children and grandchildren.

1 Provincial Context – Transforming Health Care

Ontario has a world-class public health care system that belongs to the people of this province. However, consumers, providers, researchers and policy-makers alike recognize the growing pressures on our health Care system – rising costs, an aging and growing population, new technologies, and emerging public health threats from an increasingly connected world.

The Ontario government's plan to transform health care is about creating a *comprehensive* and *integrated* system of care that is shaped *with* the active leadership of communities and driven *by* the needs of the patient.

1.1 Provincial Vision and Strategic Directions

The provincial government is committed to delivering better health care to Ontarians. This vision is driven by patients, their families, and health service providers ('providers') working together in new and different ways.

Our Vision

A health care system that helps people stay healthy, delivers good care to them when they get sick and will be there for their children and grandchildren.

Our vision is of a system where all providers speak to one another in the same language, where there are no longer impenetrable and artificial walls between stakeholders and services; a system driven by the needs of patients and not providers.

The Ministry of Health and Long Term Care (MOHLTC or 'Ministry') has set out five draft strategic directions for Ontario's health system as the basis for a 10-year Provincial Health System Strategic Plan due to be released in the spring of 2007. The five draft Strategic Directions are:

1) Renewing community engagement and partnerships concerning health care.
   - Ensuring that community awareness and engagement remain core elements / processes in local health system planning
   - Building partnerships with other participants in the local health system including Public Health and primary care groups
   - Ensuring active participation in local community planning processes

2) Improving the health status of Ontarians.
   - Improving the health of all Ontarians, especially groups with the poorest health status
   - Enhancing uptake of provincial disease screening programs

3) Ensuring equitable access to health care for all Ontarians no matter where they live.
   - Reducing wait times for key services
   - Eliminating barriers to access
   - Instilling appropriate supports to enable Ontarians to age in the most appropriate place
   - Ensuring more effective health human resource planning and management

4) Improving the quality of health outcomes.
   - Placing the consumer at the centre of planning and coordination of health services and chronic disease prevention and management
   - Improving integration and coordination of health services and facilities related to health promotion, disease prevention, diagnosis, treatment, rehabilitation, and palliative care that is based on the populations' need
   - Building leadership and participation in continuous quality improvement of the health system

5) Establishing a framework for a sustainable health system.
   - Providing equitable allocation of health resources according to the health needs of the population
   - Optimizing use of available resources to deliver health care
   - Increasing efficiency of service delivery
   - Basing planning and decision making on evidence, analysis of need and value of investment
   - Increasing use of appropriate care settings
   - Moving toward an electronic health information system
   - Ensuring financial stability

This transformation must begin with a new way of thinking and behaving. As a result, 14 Local Health Integration Networks (LHINs) have been created across Ontario as a vehicle to plan, coordinate, integrate, fund and monitor local health care services and offer innovative responses to some of the significant challenges now facing the Ontario health care system. Working in concert with other provincial initiatives, LHINs will help drive the evolution of health care from a collection of independent services to a fully integrated health system.

By devolving responsibility for health services to LHINs, the Ministry will play a more strategic role in the health system by concentrating on setting overall strategic directions and provincial priorities for the health care system.

1.2 Local Health Integration Networks – Enabling Change

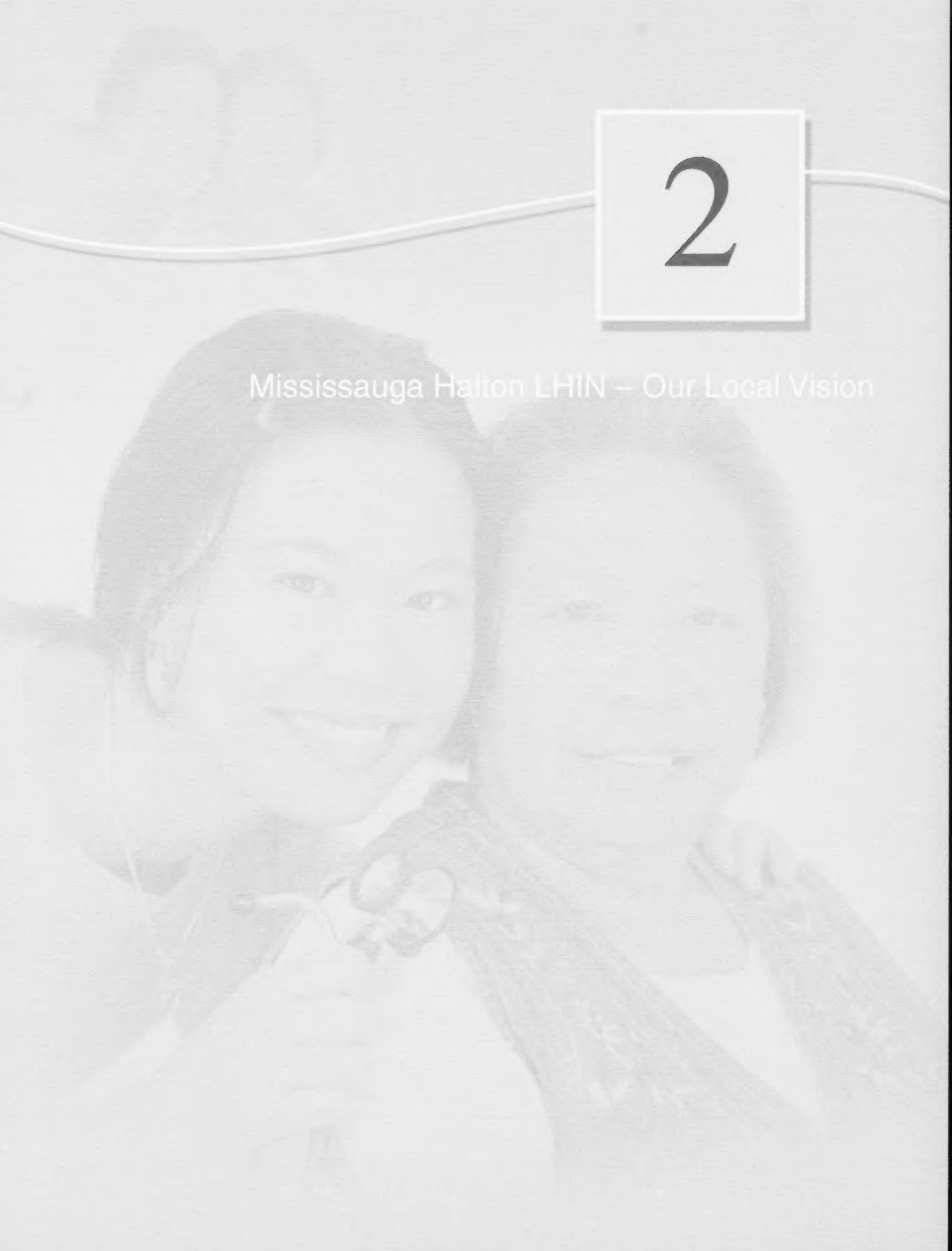
The Local Health System Integration Act received Royal Assent in March 2006, formally establishing LHINs. The implementation of LHINs is critical to transforming Ontario's health care system into a system that delivers services people need and can access in the right location.

LHINs will focus on integration and will manage health services that are delivered in hospitals, long-term care homes, community health centres, Community support services, community care access centres and community mental health and addictions agencies. LHINs are based on a principle that community-based care is best planned, coordinated and funded in an integrated manner within the local community because residents are best able to determine their health service needs and priorities.

Through improved integration and the coordination of services, LHINs will create a more efficient and accountable health system and help ensure sustainability in the longer term.

2

Mississauga Halton LHIN – Our Local Vision



The Mississauga Halton LHIN
supports integration as a
catalyst for change
within its communities.

2 Mississauga Halton LHIN – Our Local Vision

The Mississauga Halton LHIN is governed by an independent, nine member community Board. Board members are selected based on their specific skills and expertise and are appointed by the Lieutenant Governor Order-in-Council. The LHIN Board is responsible for identifying local issues and defining goals for tangible improvements to health care in the communities within Mississauga Halton. The Board provides leadership and sets strategic priorities implemented by a small team of professional staff.

2.1 Our Shared Vision

Creating an integrated health system will require shifts in how we work together and deliver care to meet the health needs of our local communities. The role of the Mississauga Halton LHIN is to promote and facilitate appropriate integration based on collected data, input from providers working within the system and the clients/patients using health care services.

The Mississauga Halton LHIN is committed to the transformation agenda. We have adopted and fully endorse the Ministry's vision of health care transformation to guide our initial efforts. We share the Provincial vision of a sustainable health care system that keeps people as healthy as possible but is there when people need care; a system that is client/patient/family[1] focused and engages providers in new ways to remove barriers and creates innovative solutions in the pursuit of effective health care.

As our communities continue to evolve and mature, the Mississauga Halton LHIN will develop its own local mission, vision and values which will incorporate the local interests and needs of the residents from our communities consistent with the province's overall vision for the health system.

2.2 Our Vision for Integration

The Mississauga Halton LHIN supports integration as a catalyst for change within Mississauga Halton communities in order to achieve a shared vision of healthy people and healthy communities through a well coordinated, sustainable service delivery system.

[1] Client/Patient/Family refers to any Patient, Client, Survivor, Resident, Consumer and other individuals who may potentially use health services and their family and/or care givers.

Integration is an important part of the evolution of health care in Ontario, moving from a collection of services that are provider-centred and uncoordinated to an easily accessible health care system that is patient-centred and responsive to local health needs. To be successful, integration will enhance existing partnerships, build new partnerships, link providers to increase communication and improve patient care, improve efficiency and optimize the use of existing resources.

Specifically, the Mississauga Halton LHIN believes that integration will:

- be viewed from the perspective of the clients/patients/families rather than from a provider focus;
- remove barriers to understanding and navigating the system;
- result in the development and implementation of system-wide best practices to improve health outcomes and capitalize on local innovations;
- deliver consistent health services through standardization of practices to promote good health outcomes and eliminate unnecessary duplication and inefficiencies;
- develop centres of excellence to maximize available human resource expertise and specialized equipment and facilities;
- improve access to quality care and provide better value for money; and
- enable reinvestment of savings to address priority health needs.

"We can't solve problems by using the same kind of thinking we used when we created them."

Albert Einstein

Strategic goals for integration are outlined below:

1) All providers will embrace a systems perspective, through language, actions and accountability for joint outcomes in the delivery of high quality client/patient/family-focused services for the residents of the Mississauga Halton LHIN.

2) Improve access to the care and services needed by our communities.

3) Ensure that our patients/consumers can more easily move through the continuum of services.

4) Promote sustainability of the health system by ensuring the most effective and efficient use of our resources

Guiding Principles for Decision Making

Criteria developed to support a 'fair and transparent' approach to decision-making and to balance both local and provincial interests was validated through community engagement. The following principles guided the development of the IHSP and continue to support decision making efforts in the execution of the IHSP.

Principles:

- Address a health need of a population.
- Promote health promotion and disease prevention.
- Incorporate evidence-based practice.
- Demonstrate innovation in service delivery.
- Contain elements demonstrating true partnership and collaboration.
- Improve access to care and services.
- Ensure that people move easily through the seamless continuum of services.
- Improve potential for the financial sustainability of the health care system.
- Positively improve the overall health system.
- Fit within the legislative and fiscal mandates of the Mississauga Halton LHIN.

2.3 Our Framework for Community Engagement

Creating an integrated and coordinated system begins with community involvement.

"There is no greater power than a community coming to grips with what it cares about."

Margaret Wheatley, Author

Engaging our Community - the Community Engagement Framework
Community engagement or involvement refers to the entire spectrum of activities that support two-way interaction between the Mississauga Halton LHIN and the public and providers in order to support health system planning and design.

The benefits of community engagement include:

- **Increased Accountability:** Community input will help us provide the right services to the right people at the right time to maximize effectiveness and efficiency of service delivery. Involving the community early and often will provide an important source of information, ensure a high level of accountability, increase "buy-in" of LHIN goals and achieve appropriate outcomes.

- **Planning that is Client/Patient/Family-focused:** Planners and providers have expertise in the decisions required throughout service delivery and the client/patient/family has the best insight of their experience and satisfaction with the system. Community engagement combines both perspectives to support more informed decisions regarding service provision and delivery.
- **Innovation:** Engaged communities often develop solutions to community issues that are more holistic, integrated and creative than those with little or no public input.
- **Improved Health Outcomes:** Health literature identifies increased control over decisions affecting communities and individuals as one of the major contributors to a healthier population.

In April 2006, the Board approved the Community Engagement Framework (see Appendix A), which outlines the many different approaches and activities that the Mississauga Halton LHIN undertook to truly engage our community. Refer to Appendix B for a detailed description of the approaches to community engagement for the IHSP.

2.4 Our Framework for Performance Management

The Performance Management Framework for the Mississauga Halton LHIN will be guided by the Provincial Strategic Plan, provincial priorities, the Local Health System Score Card and the IHSP. We are currently developing a comprehensive approach to monitor and evaluate activities of our LHIN, in order to measure outcomes of integration and improving health system performance. For an overview of the framework being developed, refer to Appendix C.

3

Environmental Scan – What We Learned and What We Heard

Growth, the aging population, and cultural diversity are critical drivers for planning and system design in the next decade.

3 Environmental Scan – What We Learned and What We Heard

This section summarizes key findings we heard from our conversations with thousands of residents, providers and partners across the Mississauga Halton LHIN. These findings further reveal the community's readiness to implement provincial priorities.

3.1 Community Profile[2]

The Mississauga Halton LHIN covers approximately 900 square kilometres, making it one of the most geographically compact LHINs in the province (Figure 1). The municipalities of Halton Hills, Milton, Oakville, Mississauga (excluding Malton) and South Etobicoke (part of the City of Toronto) are contained within the LHIN geography. The geography contains elements of urban, suburban and rural settings.

Figure 1: Mississauga Halton LHIN

Mississauga Halton Local Health Integration Network (E)
Réseau local d'intégration des services de santé de Mississauga Halton (E)
Legend / Légende
Ontario

Source: Ministry of Health and Long Term Care

LHIN boundaries were determined by the MOHLTC using methodology based on where people seek hospital services. As a result, the LHIN planning area does not correspond directly to political and municipal boundaries.

[2] A more comprehensive analysis of this overview can be found in Appendix D.

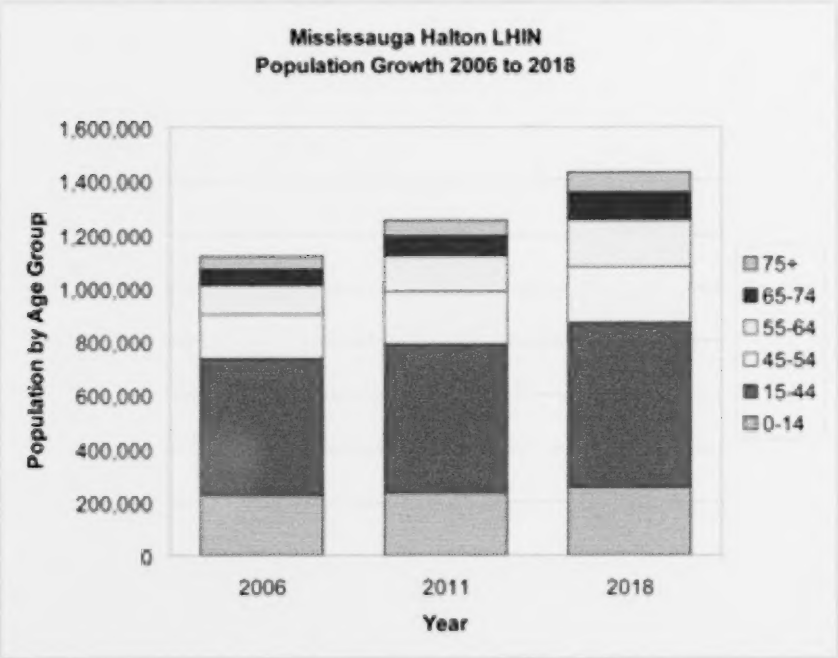
While this presents a challenge in the short-term for historical analysis, it provides an opportunity to better serve residents utilizing health services within the system. Over time data collection will align with new boundaries, improving data quality and the ability to better understand resident needs.

A Growing Population

While geographically small, over one million people live in the Mississauga Halton LHIN, making it the fourth largest LHIN in Ontario based on population. The majority of residents, 64%, live in the City of Mississauga. Significant population growth experienced for the last 10 to 15 years is projected to continue into the future.

By 2018, Mississauga Halton's population is projected to reach over 1.4 million, an increase of more than 300,000 residents and equivalent to the entire current populations of Oakville, Milton, Halton Hills and South Etobicoke combined (Figure 2).

Figure 2: Mississauga Halton LHIN Projected Population Growth



Source: Draft Unpublished Projections (2004 Base), Ontario Ministry of Finance

With an average age of 33.6 years, the Mississauga Halton LHIN population in 2006 is generally younger than the provincial average (35.6). However, while the population can generally be characterized as younger, it is aging. Over the next 12 years we will experience the second highest growth rate in the province for residents 65 plus years of age. By 2018, the 55 plus age group will represent one quarter of the total population.

This significant increase in senior-aged resident population within the LHIN will inevitably translate into:

- higher prevalence of chronic diseases such as arthritis and diabetes;
- higher incidence of the diseases of aging such as cancer, stroke and cardiovascular conditions, many requiring additional ongoing primary care support such as rehabilitation and allied health services;
- greater demand for long-term care placements within their community, including those with an ethno-cultural focus; and
- higher demand for mental health support services for conditions of aging such as Alzheimer's Disease and dementia, as well as other mental health problems such as depression and addiction, which frequently occur with physical disease.

A Culturally Diverse Population

The population of visible minorities residing within the Mississauga Halton LHIN is 10% higher than the province (refer to Appendix D, Figure 20). Communities with a significant proportion of visible minority groups include: South Etobicoke (21.8%); Southeast Mississauga (37.8%) and Northwest Mississauga (41.0%). The current top five languages in Mississauga are English, Chinese, Punjabi, Polish and Urdu. While in Etobicoke it is English, Polish, Urdu, Tamil, Spanish and Chinese.

Recent immigrants may have poor access to health care services since they are unfamiliar with the system and available services[3]. In addition, recent immigrants face language and vocational barriers that negatively influence the determinants of health. Often new immigrants with high levels of education (with a Bachelor degree or higher) cannot speak either of the two official languages and are unable to receive accreditation in Canada for equivalent international qualifications. This hinders their ability to compete in the job market effectively, increases the likelihood of living in poverty[4] and counteracts health promotion and disease prevention.

In response to the high percentage of visible minority groups in Mississauga Halton, services need to respond appropriately to different ethnic, spiritual, linguistic and familial needs. Services also need to provide equal treatment regardless of race, gender, socio-economic situation, and immigration status.

Francophone Community

Mississauga Halton's Francophone population comprises 1.9% of its total population, as contrasted with a provincial average of 4.7%. There are 15,600 Francophone residents in the LHIN but over half live in the City

[3] Robertson, Angela, and Terry Swan. LHIN Priority Integration Opportunities, Integration Opportunity: Access to Integrated Health Care for Racialized and Marginalized Communities, Supporting Background Report. Sistering: a Women's Place and Ontario Federation of Indian Friendship Centres. 2005.
[4] IBID

of Mississauga. Furthermore, 29% of Francophone's in the Regional Municipality of Peel are also a racial minority[5]. The City of Mississauga is a designated community under Ontario's French Language Services Act (FLSA). Ten health service provider organizations have been identified and are working towards official designation within the Mississauga Halton LHIN. However, to date no health service providers have been able to achieve the requirements necessary for formal designation under FLSA.

As part of the engagement process, the Mississauga Halton LHIN IHSP Steering Committee received a delegation and a written submission from Le Centre Francophone de Santé Communautaire de Mississauga Inc. on May 29, 2006. This provided an opportunity to hear about some of the local needs of Francophone residents and specifically their efforts to establish a Community Health Centre.

The Mississauga Halton LHIN was an active participant in a large Greater Toronto Area (GTA) wide Francophone Community Engagement Forum on July 5, 2006. The five LHINs within the GTA (Mississauga Halton, Toronto Central, Central, Central West, and Central East) created this joint forum to give the Francophone community an opportunity to voice their health needs and health system issues which often cross LHINs. The information and ideas heard were considered by all of the LHINs as they developed their IHSPs. The issues that have been raised locally and across other neighbouring LHINs, include the need to be able to access a continuum of services in French, from birth to end of life, from hospital care, primary care to home care.

This was the first of an ongoing dialogue between the GTA Francophone Community and the five LHINs and proved to be an effective way to engage the community.

Aboriginal Communities

The 3,230 identified Aboriginals within the Mississauga Halton LHIN form a small portion of the population (0.4%). The highest concentration within the LHIN is in Milton, where 0.6% of the population is of Aboriginal ethnic identity. The population is much smaller than in other LHINs because of the lack of First Nations' reserves within the Mississauga Halton LHIN.

Health status characteristics and non-medical health determinants of Aboriginal people are typically different from the non-Aboriginal population. For example, infant mortality, unintentional injury deaths, suicides and smoking rates are higher in Aboriginal communities. Census data for Aboriginal populations are particularly susceptible to incomplete enumeration on First Nations' reserves.

The Board of Directors and staff from the Mississauga Halton LHIN joined with the Hamilton Niagara Haldimand Brant LHIN to participate in a

[5] Statistical Profile - Francophones in Ontario. Government of Ontario Office of Francophone Affairs. September, 2005.

half-day session which was sponsored by Six Nations for the Aboriginal communities. This was an initial dialogue which proved to be an effective way to consider the specific needs of the Aboriginal community. The Mississauga Halton LHIN will continue to participate in these forums.

Socio-Economic Factors

Residents of Mississauga Halton are well educated relative to Ontario with over half of the population completing some form of post-secondary education. Oakville reflects a significantly higher degree of education than the other communities in this LHIN.

The Mississauga Halton LHIN population performs better overall than the Ontario average for socioeconomic indicators such as: the percent who are In non-owned dwellings (26% vs. 32%); percentage of low income earners (11% vs. 14.4%); population (15+ years) in the labour force (71.7% vs. 67.3%) and single-parent families (19.3% vs. 23.4%). Some areas of the LHIN perform more poorly than the provincial average on each of these indicators, which shows they may be more socio-economically "disadvantaged".

Overall Health Status

Current health status indicators for Mississauga Halton LHIN residents are in line or slightly better than the provincial average. Data from the Canadian Community Health Surveys conducted in 2003 and 2005, reflect that over 62% of Mississauga Halton LHIN residents report being in "excellent or very good health". Furthermore, Mississauga Halton LHIN residents had the second lowest prevalence of diabetes (3.8%) among the fourteen LHINs and a prevalence of arthritis/rheumatism that was significantly below the provincial average (14.0% vs. 17.1%). Mississauga Halton LHIN hospitalizations are among the lowest of all fourteen LHINs. However, Mississauga Halton LHIN residents rank the second highest among the LHINs in terms of reporting high life stress which may impact a rise in stress-related chronic disease as the population ages.

3.2 Health Services Utilization Profile[6]

There are 85 health service providers within the Mississauga Halton LHIN that are allocated funds by the MOHLTC. Per capita (on a per person basis) funding allocation for health services in the Mississauga Halton LHIN in 2004/05 was among the lowest of the fourteen LHINs. A complete list of health service providers can be found in Appendix D.

Inter-LHIN Health Service Providers

Some of our 85 health service providers serve populations in other LHINs. Similarly, health service providers located in other LHINs also serve residents in the Mississauga Halton LHIN. See Appendix D for a complete list.

[6] A more comprehensive analysis of this overview can be found in Appendix D.

Health Service Provider Profile

In the primary health care sector, the Mississauga Halton LHIN currently has: 4 Family Health Networks; 27 Family Health Groups; 32 Comprehensive Care Model physicians; 1 satellite CHC; 3 Nurse Practitioner Programs; and 6 Family Health Teams (one in each sub-LHIN area). Over 450 physicians have registered to provide care to over 480,000 residents; however, very few include the use of nurse practitioners. In 2004/05, approximately three quarters of Mississauga Halton LHIN patients visited a primary care physician within their own LHIN; however, only 55.9% of Mississauga Halton LHIN residents visited specialists within the LHIN. This rate was one of the lowest in the LHINs.

The Mississauga Halton LHIN includes several types of community support services: 1 Children's Treatment Centre; 12 Community Mental Health Agencies; 43 Community Support Services; and 6 Substance and Addictions Services. While utilization data for this sector are limited, the community mental health and addictions sectors have seen little or no change in terms of restructuring despite major reform initiatives in both sectors. As a result, these sectors remain fragmented, undersized and difficult to access.

The newly created Mississauga Halton Community Care Access Centre (CCAC) is made up of parts of three CCACs – Peel, Halton and Etobicoke-York. LHIN-level data regarding services was unavailable for analysis of home care services, therefore, data from Peel and Halton CCACs were used in this profile. Peel and Halton CCACs provided in-home health care to over 32,000 individuals, over 8,000 children received care in school programs and over 5,000 people were placed in long-term care homes[7]. The home care services used most frequently are nursing, occupational therapy, and in-home support services.

There are twenty-seven Long Term Care (LTC) homes distributed throughout the LHIN, with a mix of newer and older homes of various classes. The 2004/05 occupancy rates data suggests that there may still be some capacity in the system for additional long-term care placements. However, recent CCAC data indicates that the percentage occupancy has increased steadily over the past 18 months resulting in short waiting lists for some LTC homes. Matching supply with demand due to geographic and economic limitations continue to challenge the system.

Of the 1,091 hospital beds in operation, 60% are medical beds. Approximately 75.7% of all Mississauga Halton LHIN residents receiving acute care in Ontario went to one of the three hospital corporations within the LHIN. About 25% of residents obtain care in hospitals outside of Mississauga Halton given our proximity to major tertiary/quaternary academic health science centres on either side – Hamilton to the west and Toronto to the east. This outflow is expected to continue in the future. Residents from outside Mississauga Halton seeking care from local hospitals represented 17.4% of primary

[7] Source: Halton and Peel CCAC MIS Comparative Reports for the 2005/2006 Year End

(e.g., medical care), 20.1% of secondary (e.g., surgical care) and 36.7% of tertiary/quaternary (e.g., complex surgical care) cases.

While Mississauga Halton LHIN residents represent 8.4% of the provincial population, they account for only 6.1% of the total acute care caseload for Ontario residents. Relative to Ontario residents, Mississauga Halton residents had significantly lower age-standardized hospitalization rates[8] for all levels of acute care (62.7 vs. 72.5).

Newborns, children and youth in the Mississauga Halton LHIN represented 18,535 hospital cases in 2004/05. Over two-thirds (68.1%) were related to neonatology (care of newborns), suggesting that the most common need for this population is perinatal (period around the time of birth) care. Of the remaining causes for hospitalization, psychiatry represented the next highest number of patient days, reflecting the need for mental health and addictions services in this population. A study of student drug use in Ontario[9] indicated that Mississauga Halton LHIN students in grades 7 through 12 were below the provincial average in almost all categories of substance use and reporting of mental health conditions associated with substance abuse.

The 2004/05 data shows the proportion of Alternate Level of Care[10] (ALC) days in Mississauga Halton LHIN hospitals (6.3%) as lower than Ontario (8.9%), one of the lowest rates among the LHINs. If all ALC days were eliminated, this would translate to 66 additional bed equivalents in the system (including some conversion to other types of care such as rehabilitation, complex continuing care and long-term care beds). The largest number of ALC days occurs for patients waiting for transfer to general rehabilitation; longest waits were for transfers to Long-Term Care (LTC) homes. With the increasing level of occupancy in LTC homes, hospitals are experiencing an increase in ALC days for patients waiting placement. Re-admission rates for selected conditions appear to be comparable or lower than the provincial average.

Mississauga Halton LHIN hospitals currently operate 101 psychiatry beds. Of the roughly 3,000 patients seen, relatively few (i.e., only about 2-3%) are seen outside of the LHIN (i.e., little outflow).

Approximately 15% of emergency department (ED) visits by Mississauga Halton LHIN residents occurred in hospitals outside of the Mississauga Halton LHIN. Similarly, almost 20% of ED visits seen in Mississauga Halton LHIN hospitals were people who did not live in the Mississauga Halton LHIN. In comparison to other LHINs, there were relatively fewer ED visits and relatively fewer "non-urgent" visits. However, 40% of visits were classified as "less urgent" or "non urgent", and 4.3% (12,900) of patients triaged left without treatment.

[8] A summary rate which adjusts for variations in population age distributions over time and place. Mortality and hospitalization rates have been adjusted using the direct method and the 1991 Canadian population as the standard.

[9] Ontario Student Drug Use Survey, 2005, Centre for Addiction and Mental Health

[10] When a patient who has completed the acute care phase of treatment occupies an acute care bed while awaiting placement elsewhere (long-term care home, rehabilitation, complex continuing care, home care, etc.).

Patient satisfaction ratings of Mississauga Halton LHIN EDs are below the provincial average and ranked 11th and 12th out of 14 LHINs on several indicators[11].

Patient Flow

Almost a third of surgical day/night procedures for Mississauga Halton LHIN residents occur in hospitals outside of the LHIN. Conversely, one quarter of day/night surgeries in Mississauga Halton LHIN hospitals are people that live outside this LHIN. The main types of day/night surgery treatments are intestinal procedures and cataract treatment. Medical day/night services focus primarily on dialysis treatments with some oncology and cardiac catheterization.

The Hospital Report 2005: Complex Continuing Care[12 13], indicates that Mississauga Halton LHIN hospitals do relatively well on System Integration and Change indicators. The results of the clinical utilization and outcomes indicators suggest there are opportunities for improvement and sharing of evidence-based practice.

3.3 Community Engagement Findings[14]

The Mississauga Halton LHIN carried out an extensive community engagement process in two phases. Phase One took place in spring 2006 and was designed to educate people about the LHIN, gathered input on health care needs and identified issues that informed the draft IHSP. Phase Two of the community engagement process took place in the summer and fall of 2006 and was designed to obtain feedback on the draft IHSP and validate input received in Phase one. Overall, 3,060 people participated in more than 200 meetings and other community engagement activities.

Several methods were used to engage the community including:

- discussion forums for the public and for providers;
- a web survey for the public and a web survey for providers;
- written submissions;
- delegation presentations;
- meetings with service clubs, networks, provider forums, community leaders;
- expert panels;
- provider conference; and
- telephone poll of Mississauga Halton residents.

"I have been involved with many community engagement events, but I actually feel as though our input is being heard and will have an impact on the plan."

Anne Ptolemy,
Community Engagement
Participant – Milton

[11] Source: Hospital Report 2005: Emergency Department Care
[12] Ibid.
[13] Complex Continuing Care relates to designated chronic care beds located in a hospital setting.
[14] Detailed Phase 1 and 2 findings can be found in Appendix B

Summary of Phase One Input:

To provide a clear and simple way to organize community engagement discussions, the public was asked to comment on the health system using a life cycle approach. Providers were asked to comment on the four preliminary priority areas identified by the Mississauga Halton LHIN based on their data collection to date. Although the public and providers examined the health system through a different lens, the issues and opportunities identified were remarkably similar. This is reflected in the top five priorities that emerged from the forums:

Public Top 5	Provider Top 5
1. More physicians, nurses, and other health professionals	1. Health promotion, wellness, disease prevention supported by public education
2. Access – especially wait times	2. Access – easy entry, no wrong door, no wait times, transportation
3. Health promotion, wellness, disease prevention supported by public education	3. Information sharing across providers using technology and a common client record
4. Information for consumers about available services ("one number to call")	4. System navigation by using care maps and mechanisms to smooth transitions from one service or sector to the next
5. Information sharing across providers facilitated by technology and common client record	5. Health human resources

There was widespread support for the above top five priority areas; however, a number of issues of particular concern for specific sub-LHIN communities also emerged. These included:

- Access to services in their language of choice was a concern for the Francophone population within Mississauga.
- Some Etobicoke participants stressed the need for an urban health framework to address the community's rich cultural diversity and the challenges of poverty and homelessness.
- The more rural communities of Georgetown and Milton placed high priority on transportation, services and supports for the hearing impaired, high risk obstetrical services, mental health counselling and expansion of the Milton hospital.

Providers were supportive of the four preliminary priority areas identified by the LHIN: chronic disease prevention and management; mental health and addictions; primary health care and seniors' health and wellness. Providers agreed with the need for system-wide initiatives that cross all four areas as well as: health human resources; infants, children and youth; persons with disabilities; palliative care; emergency departments; diagnostic services; pandemic planning; back office integration; vocational rehabilitation and the homeless population.

Summary of Phase Two Input:

Public participants reported that their views had been heard regarding a need for a greater focus on wellness, the need to remove barriers to access and the need to make mental health and addictions a priority area. Participants felt that more emphasis on children and youth as a target population would improve the IHSP. Other areas suggested for inclusion In the IHSP dealt with; the role of the consumer as an active partner; supports for cultural/linguistic diversity; reduced wait times; after hours care; increased use of nurses; nurse practitioners and pharmacists; home care and integration of health sectors; and transportation.

Potential barriers to success were identified as: public and provider buy-in, lack of public awareness of LHINs, historical funding gaps, lack of a common database and good information system, communication, dissemination of information, problems accessing specialized services in other LHINs, creating multidisciplinary teams and changing attitudes.

Public participants felt that success would be reflected in more positive experiences with the health system such as shorter wait times, easier access, less fragmentation, better information sharing across providers and access to language interpreters. Suggested indicators to monitor success would address access to family doctors, hospital re-admissions, referrals, emergency department wait times, consumer and provider satisfaction and service provider adherence to standards.

Providers took part in discussions about specific priority areas. Below is a summary of their feedback.

Strengthening Primary Health Care

Improving the Plan	Challenges
• More emphasis on mothers, babies and children • Recognition of solo providers • Reduced wait times for diagnostic tests	• Funding • Information technology • Health human resources • Linking general and specialty care • Creating new partnerships • Providing after-hours care

Enhancing Seniors' Health, Wellness and Quality of Life

Improving the Plan	Challenges
• More emphasis on community-based care • Transportation and transition support • Integration of palliative care	• Public education • Barriers to access • Health human resources • Information Systems / technology • Creating infrastructure to support the proposed model • Exclusion of physicians from LHIN funding envelope • Transportation

Preventing and Managing Long-Lasting (Chronic) Conditions	
IMPROVING THE PLAN	CHALLENGES
• More emphasis on health promotion and disease prevention and co-morbidities, pain management • Ambulatory care • System navigation and case management • Incorporate cultural aspects • Broaden rehabilitation action plan • Link to pressures in the acute	• Creating centres of excellence • Linking with disease associations and other sectors • Setting priorities • Forming interdisciplinary teams • Information systems / technology • Public education • Patients without family doctors • Transportation

Integrating Mental Health and Addictions Services	
IMPROVING THE PLAN	CHALLENGES
• More emphasis on addictions • Concurrent disorders • Dual diagnosis • Health promotion and disease prevention • Stress need for more resources	• Funding • Stigma • Transition from children's system to adult system • Cross LHIN service provision • Linkages across sectors • Insufficient psychiatrists • Transportation • Outcome measures

Members of the public expressed a willingness to be involved by participating in LHIN community engagement events, attending LHIN board meetings, spreading the word to others, helping to evaluate the success of the plan, being "consumer champions" and influencing public policy. Providers are prepared to support health system planning as participants, advisors, Champions and advocates. They are willing to share information and expertise and collaborate with other providers. Providers also recognize their critical role in implementation of the action plans such as: providing client-centred care, learning new ways to deliver care, supporting cultural shifts and changes in attitudes, working with others to refine best practices and educating the public about self-care, health promotion and disease prevention

Key Research Findings

A marketing research[15] firm was engaged by Mississauga Halton LHIN to conduct primary research on opinions and beliefs of LHIN area residents concerning their local health care system. A telephone study was conducted from August 21 to September 6, 2006. A total of 601 interviews were completed and the final data were statistically weighted to ensure the results were representative of the population of the Mississauga Halton LHIN catchment.

[15] See Appendix B

Telephone Survey Results

- Overall, the results of the poll show that there is high to moderate satisfaction with, and confidence in, local health care in the Mississauga Halton areas. This depicts a positive public opinion context for the LHIN.
- There is strong support for key integration priority areas.
- The residents of the Mississauga Halton LHIN have high expectations for an integrated local health care system that focuses on wellness and involves patients in decisions about their own care.
- Unaided awareness of LHINs is low, although half of residents say they are aware once provided with a description.
- There is a resident demand for more LHIN information.

3.4 Provincial Priorities: Assessing the Local Context[16]

The Mississauga Halton LHIN will monitor the progress of provincial initiatives at the local level and assist in their implementation. In particular, ongoing support and investment to implement the provincial e-Health Strategy and provincial leadership for a health human resources strategy will be critical to the success of the Mississauga Halton LHIN Integrated Health Service Plan.

3.4.1 Information Management / Information Technology (IM/IT)

There are two areas for reporting on IM/IT including the 2005 assessment of Electronic Health Record (EHR) Readiness and the development of the e-Health Steering Committee focused on supporting the Information and Technology Solution needs of the integration priorities.

Need for Enhanced Electronic Information Capability

Greater investment in electronic information capabilities will improve communication, make useful information accessible and streamline the health care system.

The Mississauga Halton LHIN is working with the province to generate major investments in enhanced electronic health (e-Health) information capabilities to support integration and improved quality of services within our LHIN. An effective e-Health strategy will:

- achieve integration of service delivery within and across our regions;
- make it easier for people to do their jobs well;
- engage people in their own health and wellness;
- bring sustainable value to the health care system; and
- ensure better health outcomes.

[16] A full description of these initiatives is included in Appendix E.

2005 EHR Readiness Survey

The Mississauga Halton LHIN has demonstrated a strong capability in electronic sharing: 40% of information was shared between hospitals, 29% between physicians and 10% between other health care organizations. The sharing rates in most cases are higher than the provincial averages of 21%, 22% and 14%, respectively[17]. Information sharing consists of admission histories, discharge summaries, patient referrals, drug profiles, lab and diagnostic results, surgical/procedural reports and ED visit encounter summaries. This is a reflection of the current collaboration that exists among organizations and is a strong indication of the Mississauga Halton LHIN's interorganizational readiness to incorporate the electronic health record and other critical information and technology solutions needed to support the successful achievement of Action Plans within the IHSP.

The Mississauga Halton LHIN was ranked fourth out of 14 in 2004/05 in the area of fiscal expenditures on EHR in comparison to the other LHINs, which was still below the provincial average, suggesting that greater investment is required within this LHIN.

e-Health Steering Committee

Mississauga Halton has established an e-Health Steering Committee. The mandate of this group is to provide leadership in the development of an e-Health strategy that focuses on further integration across the LHIN by maximizing information and communications technology effectively. This committee will work in cooperation with the MOHLTC to support the achievement of the provincial vision for e-Health in Ontario. For a detailed description of the e-Health Steering Committee please refer to Appendix E.

The following three strategic directions were selected by the e-Heath Steering Committee:

1) Provide the infrastructure and enablers required for the achievement of all strategic initiatives.

2) Improve information sharing within communities and across the continuum of care.

3) Improve the management and prevention of chronic diseases including engagement of client as partners in their care by providing access to useful information.

Detailed Planning and Action Teams established to execute the strategies within the IHSP will collaborate with the e-Health Steering Committee to clarify requirements of information and technology solution needs within each priority.

[17] Ontario Hospitals Connected for Care: 2005 EHR Readiness Survey Report for Mississauga-Oakville Local Health Integration Network. OHA EHealth. 2005.

3.4.2 Health Human Resources

With a growing population and an aging workforce, Health Human Resources (HHR) is becoming an increasingly important issue for the entire health sector in Ontario. For the Mississauga Halton LHIN, the challenge of recruitment and retention of health human resources is exacerbated by significant population growth. Halton Hills and Milton have been designated as "under-serviced areas" (USA) for family physicians.[18] In addition, the Canadian Community Health Survey (CCHS, 2003) estimates 6.6% of Mississauga Halton LHIN residents do not have a regular medical doctor.[19] About a quarter of Mississauga Halton LHIN residents are seeking physician services outside their local community, as 74.8% of patients visited a primary care physician within their own LHIN. For specialists, this statistic drops to 55.9%, one of the lowest among the LHINs. Nursing supply is also relatively lower in our LHIN. The nursing per capita for the Mississauga Halton LHIN was 5.5, significantly lower than the provincial rate of 9.1 and twelfth among the LHINs. Our LHIN is relatively well resourced with allied health professionals (e.g., pharmacists; physiotherapists; dietitians and midwives). For the detailed analysis of the current state, refer to Appendix E.

To address unfavourable health human resource supply issues, the following strategies will be developed over the coming months.

3.4.3 Mississauga Halton Approach to Health Human Resource Planning

A system-wide approach to addressing health human resource issues will be championed by the Mississauga Halton LHIN through the following initiatives:

1) The development of a Human Resource Advisory Group that includes representation from all sectors. Terms of Reference to be determined.

2) Use of medical directives to maximize the scope of practice for all regulated health professionals.

3) A Family Medicine Teaching Unit, part of the Department of Family and Community Medicine, University of Toronto, will be established at Credit Valley Hospital, and is being considered at Trillium Health Centre. Future graduates of this program will receive inter-disciplinary experience within our LHIN and within our local academic Family Health Team. This may encourage graduates to stay and practice within the Mississauga Halton LHIN and help decrease the number of orphan patients (patients without a doctor) and increase the number of practicing physicians. However, teaching responsibilities also put

[18] Ontario Hospitals Connected for Care: 2005 EHR Readiness Survey Report for Mississauga-Oakville Local Health Integration Network. OHA EHealth. 2005.pg 18

[19] LHIN Population Health Indicators, version 11

pressure on the ability of community hospitals to keep operating costs at current levels and to provide timely service.

4) Strategies will be developed to attract and retain non-regulated health professionals.

5) As set out in the Local Health System Integration Act, 2006, the Mississauga Halton LHIN will establish a Health Professionals Advisory Committee. This committee will be an advisory body that consists of members from a regulated health profession. This committee will provide advice on health human resource planning as well as other issues.

6) Leadership Interchange – This is an innovative approach to building leadership capacity that was championed by the human resource leaders within Halton Healthcare Services, the Credit Valley Hospital and Trillium Health Centre. Objectives of this leadership interchange are:

- To develop leadership attributes required for future success.
- To create integration leaders who understand the breadth of the continuum of care.
- To attract and retain leaders.
- To promote integration through increased awareness of the challenges facing other organizations.
- To lead integration initiatives across the LHIN.

3.4.4 Wait Times Strategy

The Mississauga Halton LHIN has established an active Wait Times Group which represents all area hospitals and the Mississauga Halton CCAC, to develop local solutions to the province's wait time priorities. The focus of the Wait Times Group is to further improve access and quality across the entire LHIN for the following priority areas:

- Cancer surgery
- Cataract procedures
- Total joint replacement
- MRI and CT Scans
- Cardiac procedures
- Surgical throughput efficiencies

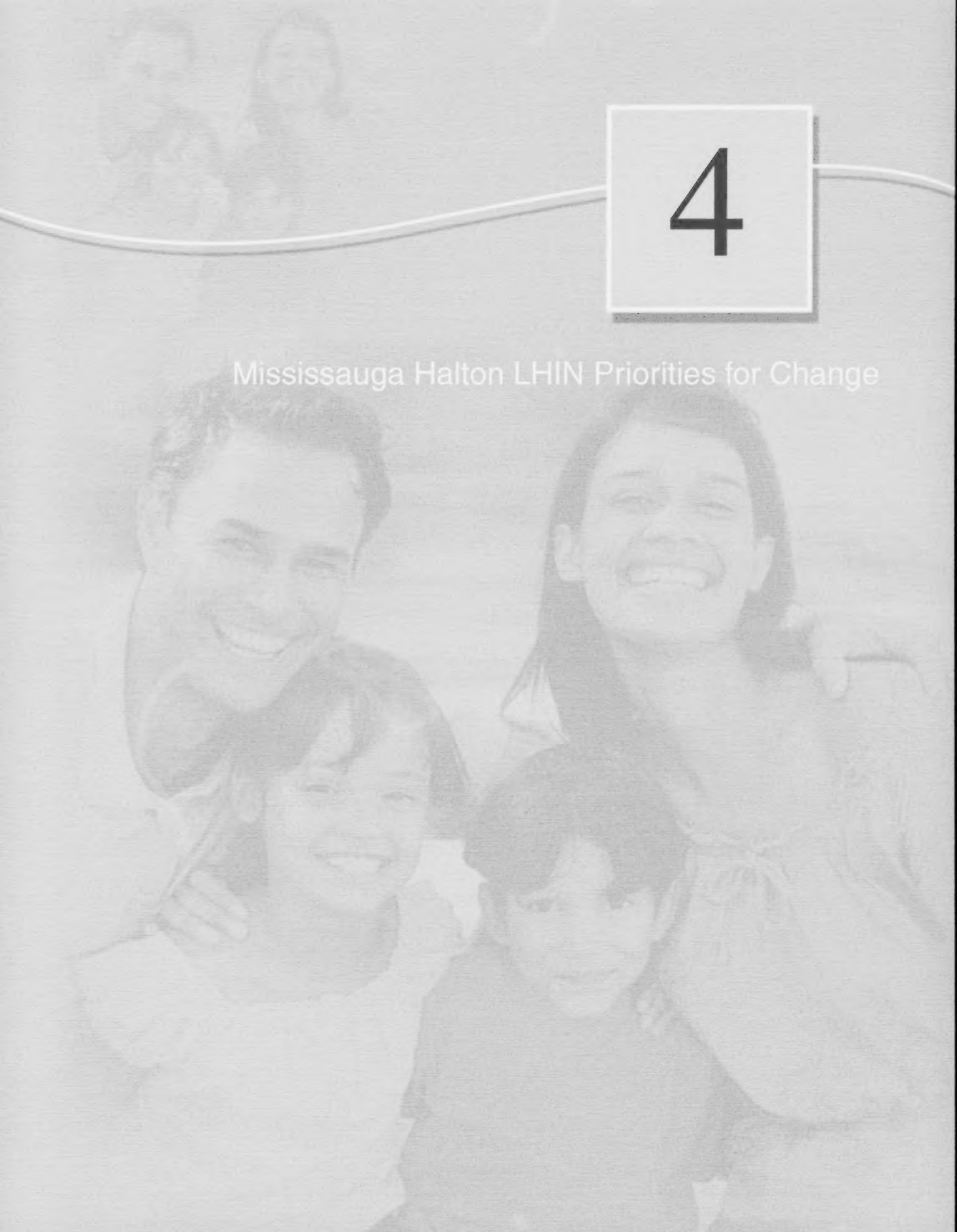
The most current wait time data were available for June/July 2006. For the detailed analysis of the results, refer to Appendix D.

Since the first comprehensive wait time data were collected in 2005, the Mississauga Halton LHIN has seen decreases in most of its wait times including significant drops for cancer surgery, angiography, cataract surgery, and for MRI scans. All are currently at or below the baseline values. Despite a recent increase in cataract surgery wait times, the figures are well below the provincial values, and closing in on the provincial target of 182 days. More than 90% of Mississauga Halton's cancer cases are done within the priority wait time target of 84 days (12 weeks).

Hospitals in the Mississauga Halton LHIN have received $22.6 million in additional funding from the Ministry of Health and Long-Term Care for 3,070 cataract surgeries; 1,245 hip and knee replacements; 1,230 cardiac procedures; 570 cancer surgeries; and 17,200 MRI scans.

4

Mississauga Halton LHIN Priorities for Change



Our final integration priorities include: Improving Health System Performance, Strengthening Primary Health Care, Enhancing Seniors' Health, Wellness and Quality of Life, Preventing and Managing Long-lasting (chronic) Conditions, and Integrating Mental Health and Addictions Services. These priorities overlap considerably and are interdependent.

4 Mississauga Halton LHIN Priorities for Change

This section outlines key local drivers for change and strategic priorities that address our challenges based on the information we obtained from our community engagement process.

4.1 Key Local Issues and Challenges

Even though the Mississauga Halton LHIN population is generally younger, more educated and in better health currently, in comparison to the province, we have unique challenges that require innovative solutions. Key local issues include:

1) Growth:
Over the next 12 years the area will continue to experience significant growth that will further tax a system currently under capacity pressures, across all sectors. The Mississauga Halton LHIN must work with the MOHLTC, the providers and the public to create local solutions for this looming challenge.

2) Aging:
By 2018 we will see an increase of over 67%, of seniors aged 65+, the second highest rate in the province. Given that age is the greatest predictor of increased prevalence of illness and use of health services, the Mississauga Halton LHIN must begin fundamental change in the delivery of services to the 55 plus population to ensure a more proactive, wellness focus to health service delivery for this target population.

3) Capacity:
Predicted, rapid growth will continue for the foreseeable future creating greater demands for hospital services within the Mississauga Halton LHIN. Hospital capacity is a major issue for our communities. In early fall of 2005 the MOHLTC announced much needed funding for the expansion of Credit Valley Hospital (to begin in 2007), Halton Healthcare Services – the Oakville Hospital site (to begin late 2006 to early 2007) and the major expansion at Trillium Health Centre (to begin in 2006). Although this will address capacity issues in the long term, significant capacity and service pressures related to population growth continue to overtax our hospitals.

4) Funding:
Although the MOHLTC has increased funding across all sectors in recent years, the average expenditure of health dollars in the Mississauga Halton LHIN remains consistently and significantly below the provincial average.

5) Diversity:
The cultural and linguistic differences that exist within the Mississauga Halton LHIN will require providers to plan, innovate and deliver services in a culturally competent way to meet the needs of local residents.

The cultural diversity of the Mississauga Halton LHIN will give rise to excellent opportunities for innovative ways to address the challenges that are especially evident among some Mississauga Halton LHIN long term care homes, but they also create new challenges in programming and respecting cost constraints.

Growth, the aging population, capacity, funding levels and diversity are Critical drivers for planning and system design in the next decade. The priority strategies that follow in this section focus on addressing these issues proactively.

4.2 Local Integration Priorities

Integration priorities were selected and validated using the methodology outlined in Appendix F. Our final integration priorities include:

- Improving Health System Performance
- Strengthening Primary Health Care
- Enhancing Seniors' Health, Wellness and Quality of Life
- Preventing and Managing Long-Lasting (Chronic) Conditions
- Integrating Mental Health and Addictions Services

Figure 3: Overview of the Five Integration Priorities, Enabling Strategies and Local Solutions for Provincial Priorities

Improving Health System Performance
Local Solutions for Provincial Priorities:
• Alternate Level of Care
• Surgical Throughput
• Critical Care Capacity
• Wait Times
• Long-Term Care Placement Time
• Quality of Care - Patient Perception
• Readmissions for Acute Myocardial Infarction
Integrating Mental Health & Addictions Services
Preventing & Managing Long-lasting (Chronic) Conditions
Strengthening Primary Health Care
Enhancing Seniors Health, Wellness & Quality of Life
Enabling Strategies:
• Information and Technology Solutions
• Human Health Resources Planning
• Promotion and Prevention
• Education and Knowledge Sharing
• Transportation
• Easy Movement Through the System

As depicted above, the LHIN's five integration priorities overlap considerably and are interdependent. For example, the integrated service delivery model for seniors is built on a robust primary health care foundation, incorporates the tools and techniques of the chronic disease prevention and management model since seniors frequently experience multiple chronic conditions and recognizes the integration needed with the service delivery of Mental Health and Addictions with respect to psycho-geriatrics. These interdependencies are further outlined in the Improving Health System Performance priority and will be managed through the Detailed Planning and Action Phase utilizing proactive project management techniques.

Each of the integration priorities is summarized in sections 4.2.1 to 4.2.5. Complete descriptions of the full priority are included in Appendix G.

4.2.1 Improving Health System Performance[20]

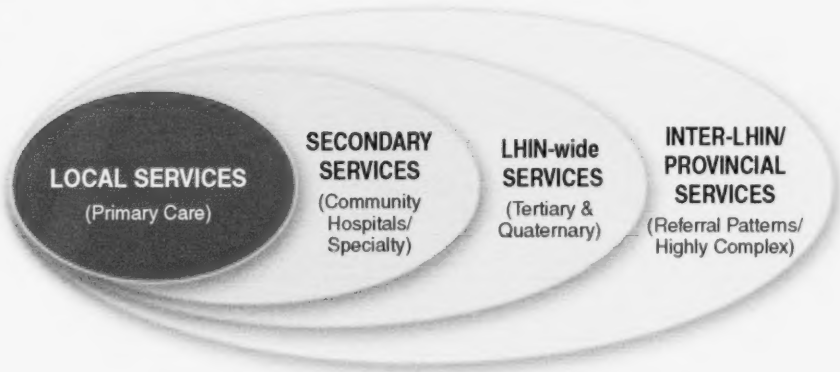
Description

To achieve our integration goals of easy access to quality services as effectively and efficiently as possible, an overall systems view is necessary to coordinate all aspects of the priorities. This system level priority recognizes and integrates the interdependencies across our other priorities. As the overview to the integration priorities suggested, the five priorities and enabling strategies are not mutually exclusive. As a result, it is critical to understand that the other priorities will supply this system priority with data and information that will support analysis across the system both vertically and horizontally. A systems view will facilitate the understanding of the 'ripple effect' that closure or significant change in services and programs have on the system and the impact on access. This is a level of analysis that has been missing within our current approach as often the balancing of budgets that is perceived as good for one organization has detrimental effects on the provision of services across the system.

"There does not have to be winners and losers, but there needs to be an exchange between organizations."

Dr. Terry Sullivan
President and CEO,
Cancer Care Ontario

The focus of this priority is to maximize expertise across the network and ensure critical mass (a large enough population to warrant service) to deliver high quality services at the most appropriate level. The right set of core services need to be identified at the local, secondary, LHIN and inter-LHIN and provincial levels.



We recognize that all communities are not the same and that local planning and service development is necessary to meet the unique needs of our residents. The fundamental principle driving our system thinking is that services should go to patients in the local community. However, when services require critical mass, specialized equipment or expertise, the client/patient will need to travel to the service.

[20] Refer to Appendix G.1 for the full details of this Priority.

Integration Innovations

To continue to build partnerships in achieving our collective goals within the IHSP, we require a process to collect, evaluate and appropriately resource innovative ideas that align with the strategic priorities of the LHIN.

Environmental Scan

The specific health needs of local communities vary based on unique characteristics and needs. Where possible, the environmental scan looks at "sub-LHIN" communities in addition to the LHIN overall for each demographic and socio-economic indicator. The "sub-LHIN" communities include Halton Hills, Milton, North-West Mississauga, Oakville, South-East Mississauga, and South-West Etobicoke.

While Mississauga Halton has good health status overall, pockets of greater risk based on socio-economic determinants of health exist. Figure 4 demonstrates the differences that exist at the local community level and underscores the need to support local services for local communities.

Figure 4: Composite Socioeconomic Indicator Map

Community Engagement

A sample of what we heard:

- Require access to timely care within a reasonable distance; services available locally or transportation to those that are available regionally
- Improved patient/client experience; patient-centered care; physicians spend more time with patients
- Increased focus on health promotion and disease prevention

- Increased individual responsibility for one's own health
- Increase focus on population health results/outcomes
- Increased sharing information across providers through an integrated information system; one patient health record
- Eliminate unnecessary duplication of services
- Ensure efficient and sufficient resources which are allocated and aligned to priorities, including health promotion and disease prevention

Overview of Action Plans

1) **Strengthen coordination and integration across providers to improve client/patient access and movement across the continuum.**

2) **Develop innovative local solutions to provincial priorities in partnership with providers across the LHIN.**

4.2.2 Strengthening Primary Health Care[21]

Description

There is an abundance of compelling evidence that a strong primary care infrastructure can lead to improved population health status and reduced health system costs.[22]

The importance of having a strong primary health care system and the overwhelming support for this priority in the community demands a concerted effort to:

- Improve and promote inter-disciplinary practice and inter-provider collaboration; and
- Focus efforts to improve the continuum of services for specific populations including mothers and babies and children and youth.

Improving and promoting inter-disciplinary practice and inter-provider collaboration:

Building mechanisms that support an integrated and comprehensive primary care system must include physicians who work in inter-disciplinary practices as well as those who work independently or in small group practices. Figure 5 illustrates a more integrated approach to primary care for those physicians who practice independently or in small group practices. In this model providers are not co-located and the family physician or another health service provider can play a case coordination role by providing linkages to other providers.

The goal is to ensure all patients get the level of primary health care service that is needed; the scope of practice of each primary care health professional will be maximized in order for family physicians to have more time for practicing medicine.

[21] Refer to Appendix G.2 for the full details of this Priority.

[22] Starfield, B. and Shi, L., "Policy Relevant Determinants of Health: An International Perspective," Health Policy, 2002, 60: 201-18.

Access to an electronic inventory of services (ideally web-based) including access methods and referral forms improves the efficiency of this model.

Figure 6 depicts primary care inter-disciplinary practices where services are co-located to provide integrated and comprehensive care to patients. Co-location facilitates ongoing two-way communication and more immediate problem solving. Maximizing the scope of practice of each health professional is critical in both models to ensure optimal efficiencies are achieved.

Figure 5: Model for Solo and Small Group Practice Family Physicians

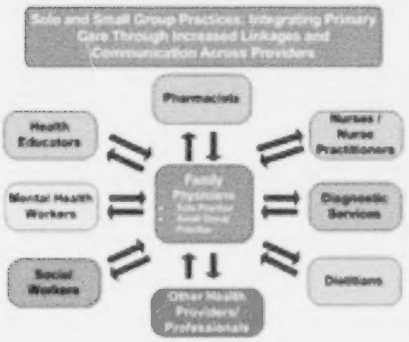
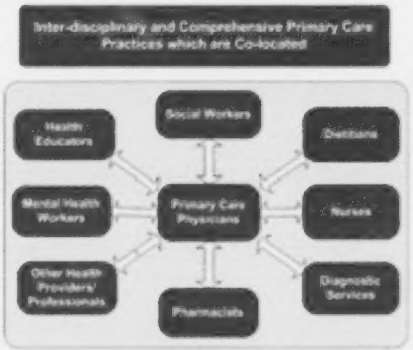


Figure 6: Model for Inter-Disciplinary Practice Family Physicians



"The centrality of primary health care is important for any system."

Dr. Nick Kates
Family Physician and Vice-Chair of Clinical Services, McMaster University

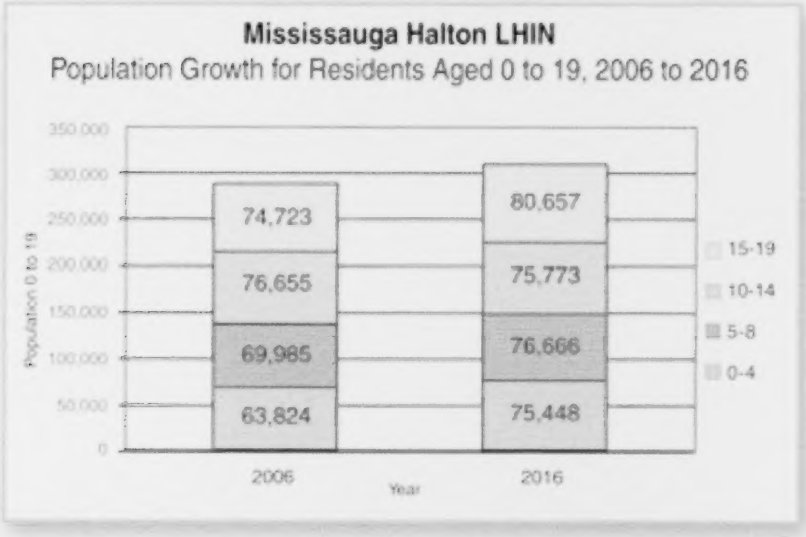
Focus efforts to improve the continuum of services for specific populations – mothers and babies and children and youth:

The need to focus on mothers, babies, children and youth within primary care is critical to the population within the Mississauga Halton LHIN. Most children receive the bulk of their health care services from primary health care service providers and partners. Public Health departments have lead responsibility for the postpartum (services following birth) component. They work with hospitals, midwives, community care access centres, physicians and other community partners across the health and social services sectors to implement the postpartum and early identification component of Healthy Babies, Healthy Children. A strong infrastructure needs to be available for those who cannot always advocate for themselves.

Environmental Scan:

- The population growth for the 0 to 19 age group over the next decade is projected to be 49,478 or approximately 17.3% which is significantly higher than the province overall.

Figure 7: Mississauga Halton LHIN Population Growth



Source: Unpublished Draft Projections (2005 Base), 2006-2016, for Local Health Integration Networks

- Approximately 40 per cent of emergency visits are classified as "less urgent" or "non-urgent". This suggests that there is some opportunity to offer other means of non-urgent or emergent treatment (service areas or treatments) in other ways.

- As of 2004, there were 732 family physicians in the Mississauga Halton LHIN. This translates to approximately 1 physician per 1,422 people. This ratio is lower in Halton Hills and Milton and they have been designated as "under-serviced areas" for family physicians.

Community Engagement

A sample of what we heard:

- Develop inter-disciplinary team approaches for primary care
- Improve communications/linkages among providers
- Provide more home support for moms and babies (e.g., postpartum follow-up for new mothers and newborns)
- Increase community primary care resources – local and available longer hours
- Children and youth need a higher profile within the IHSP priorities
- Investigate how we might provide better services in the community to handle acute episodes for children
- More alternatives to the emergency department are needed to access non-urgent care

Overview of Action Plans

1) **Strengthen inter-disciplinary practice across providers by improving communication and linkages among physicians and primary health service providers and partners.**

2) **Improve and strengthen support programs available for expectant mothers, new mothers and newborns.**

3) **Enhance inter-disciplinary service delivery and service availability to children and youth to better meet the needs of this population throughout the LHIN.**

"Make seniors good health a priority in your community by going beyond health service providers and working with your community leaders."

Donna Cripps
President and CEO, St.Peter's Health System

4.2.3 Enhancing Seniors' Health, Wellness and Quality of Life[23]

Description

A broad-based group of local stakeholders with expertise in senior's health have taken the initiative to develop an evidence-based, integrated service delivery model for seniors in the Mississauga Halton LHIN. The working title for the model is "ASSIST", which stands for:

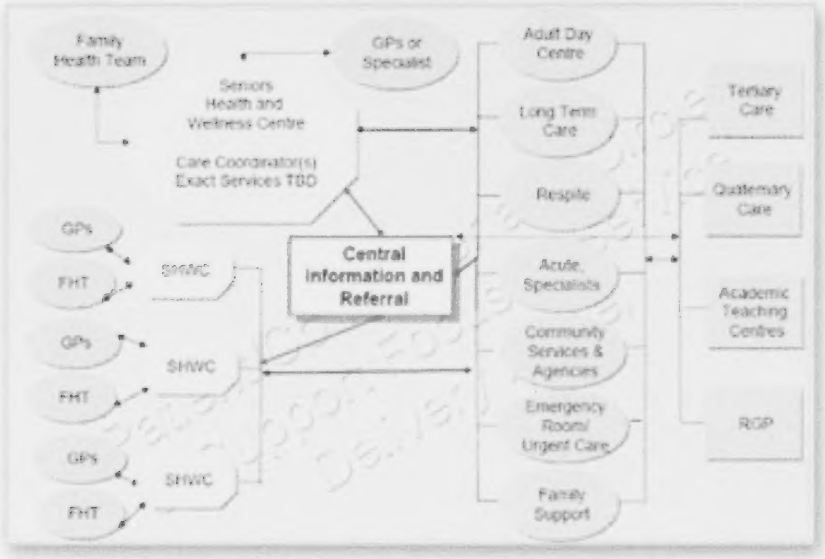
- All-inclusive Seamless Services for Independence of Seniors for Today and Tomorrow[24]

The target population will be adults age 55 or older residing in the Mississauga Halton LHIN. Although seniors are typically defined as age 65+, a broader age range was deliberately selected for the model. In keeping with evidence-based practices for chronic disease management, It was important to target a younger population for proactive health promotion, disease prevention and wellness interventions that may delay or prevent onset of disease in the future. Innovative approaches to service delivery will need to consider the transportation challenges experienced in accessing care for this population.

[23] Refer to Appendix G.3 for the full details of this Priority.

[24] The Regional Geriatric Advisory Task Force completed a detailed examination of the best practices in service delivery to the frail elderly, seniors and other innovative integrated service delivery models and as a result a report and delegate presentation was made to the Mississauga Halton LHIN for inclusion in their IHSP – the Description of the priority and Action Plan #1 is a direct result of the design, development and implementation planning completed by this cross-sectoral team.

Figure 8: All-inclusive Seamless Services for Independence of Seniors for Today and Tomorrow



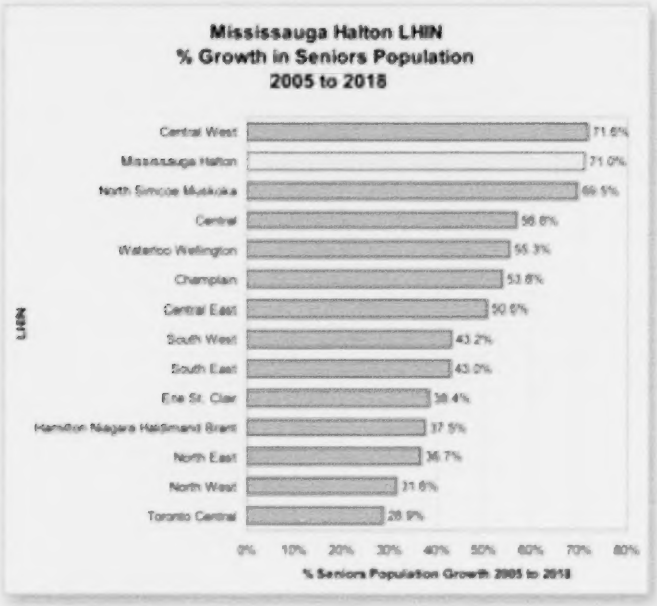
The proposed model:

- Builds on primary health care.
- Incorporates health promotion and disease prevention.
- Describes Seniors' Health and Wellness Centres ('SHWC') that are geographically dispersed and interconnected hubs that provide common information, intake, assessment, referral and primary care service delivery.
- Facilitates access to services through any of the providers or Central Call-in number.
- Enables navigation through Care Coordinators linked to primary care physicians/FHT through the SHWC and are integral to system navigation and service delivery.
- Enhances the role and service delivery within Long Term Care homes.
- Integrates with the End-of-Life strategy to enhance the delivery of palliative care.

Environmental Scan

While Mississauga Halton LHIN is ranked 5th in overall population growth, in seniors (65+ years of age), we are projected to have the second highest growth rate (i.e., percentage increase) in seniors to 2018 among the fourteen LHINs.

Figure 9: % Growth to 2018 in seniors (65+) population



Acute hospitals are the most costly sector of the health care system; seniors are heavy users of acute hospital services:

- Over 20% of emergency department visits to the Mississauga site of Trillium Health Centre are for people over the age of 65.
- Patients over the age of 65 represent 37% of the total admissions to the Credit Valley Hospital's emergency department. Their length of stay was longer than patients with the same diagnosis under the age of 65.
- Seniors comprise 47.5% of all admissions to Halton Health Care Services.

Community Engagement

A sample of what we heard:

- Develop a regional geriatric program
- Develop a "seniors community" (concept of "aging in place") with supportive housing, recreational activities, etc.
- Develop a falls prevention program
- Establish more palliative care teams
- Expand caregiver support programs including respite for caregivers to seniors, parents of children with special needs, etc.
- Enhance resources, increase use of nurse practitioners and develop designated units in LTC homes
- Recognize the challenges seniors face in transportation

Overview of Action Plans

1) **Execute the detailed planning and implementation of the integrated service delivery model for seniors.**
2) **Enhancing the role of long-term care homes.**
3) **Building on the End-of-Life Strategy to develop a comprehensive approach for Palliative Care.**

4.2.4 Preventing and Managing Long-Lasting (Chronic) Conditions[25]

Description

A chronic disease is an illness, functional limitation or cognitive impairment that lasts (or is expected to last) at least one year, limits what a person can do and requires ongoing care.[26] Some examples of chronic disease include asthma, arthritis, diabetes, and congestive heart failure. Chronic disease prevention and management (CDPM) is a pro-active, population-based approach that addresses chronic diseases before they begin, through health promotion or early detection, to reduce the rate of disease progression and potential health complications. CDPM delays the need for medical interventions and is an important aspect of primary health care, health promotion and disease prevention activities.

Many chronic diseases are preventable with education and behavioural/ lifestyle changes. CDPM focuses heavily on health promotion and disease prevention both for at-risk individuals and the general population and helps people maintain their independence.

The Framework

The Ontario CDPM framework is built on evidence-based models and reflects this province's commitment to keep people healthy, takes an individual and family-centred approach and encourages community involvement.

The CDPM Framework represents a systems approach that will lead to more productive interactions and relationships among individuals and their families, health care organizations, and the community that will in turn lead to better individual health outcomes, better population health outcomes, and better use of health resources.

"When it comes to managing chronic diseases, the practitioners can do about 20% of what an individual needs, but the other 80% comes from the person him or herself."

Merrickville CHC

[25] Refer to Appendix G.4 for the full details of this Priority.

[26] Source: National Academy of Social Insurance, "Medicare in the 21st Century: Building a Better Chronic Care System," January 2003.

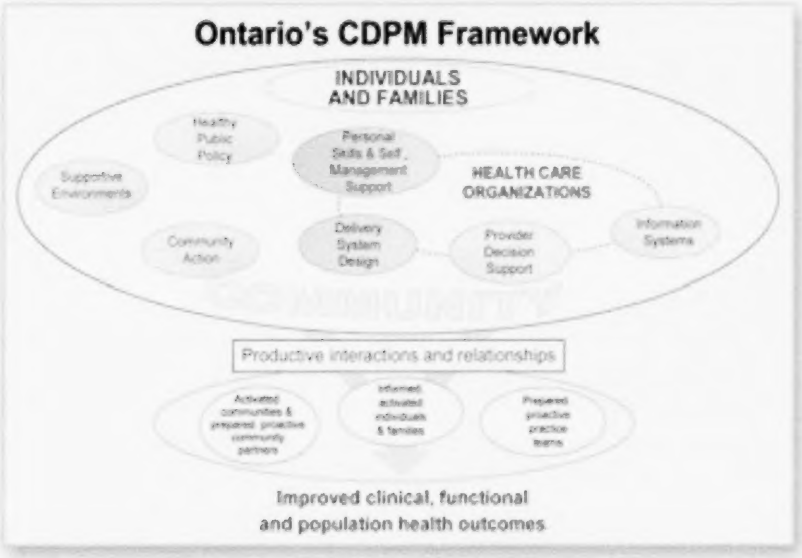
"We need to understand all of the challenges within CDPM. We are facing a tsunami that is bearing down on us, and we are not yet prepared"

Dr. Andrew Pipe
Physician and Director of The Minto Prevention & Rehabilitation Centre, Ottawa

This approach includes both prevention and management of chronic disease, and incorporates health promotion for everyone including: people who are healthy, people at risk of developing a chronic disease, and people with one or more chronic conditions.

It emphasizes the importance of collaboration between health care organizations and the community, and with individuals and families to prevent and manage chronic disease. When the CDPM framework is used to guide care, it changes the individual's relationship with health care practitioners as well as his or her experience with the health care system.

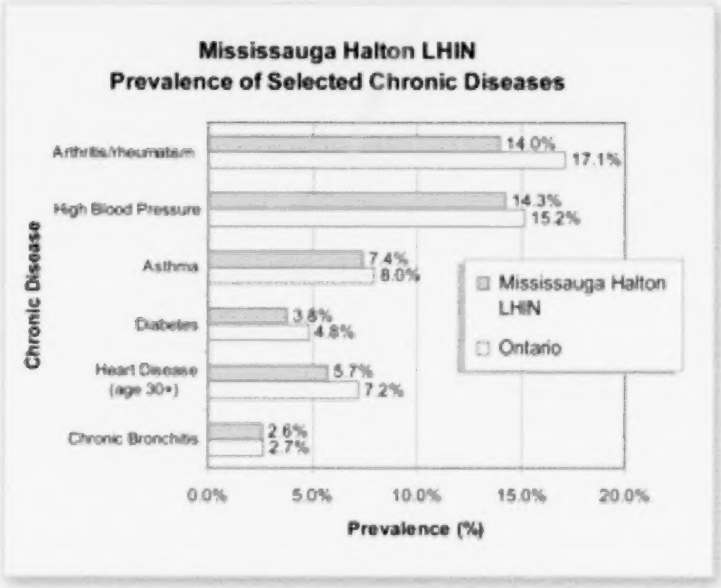
Figure 10: Ontario's CDPM Framework, developed by the MOHLTC is shown below:



Environmental Scan:

- Mississauga Halton LHIN is home to approximately 215,000 adults over the age of 55. It is also the fastest growing LHIN region in the province. In the next decade the number of older adults will increase 48% to over 317,000. This poses a significant challenge for the local health system. Chronic disease including strokes, heart disease and osteoporosis are exacerbated by age.
- Figure 11 highlights the prevalence rate for selected chronic diseases in Mississauga Halton and Ontario. Mississauga Halton has a higher prevalence of asthma than the province as a whole.

Figure 11: Prevalence of Selected Chronic Conditions (age 12+), Mississauga Halton LHIN and Ontario



Source: Canadian Community Health Survey, Mississauga Halton LHIN Population Profile

Community Engagement

A sample of what we heard:

- Ensure providers get the right, accurate information
- Managing multiple conditions per patient is the norm
- Establish a team approach to deal with the complexities of the conditions – critical mass
- Work across and with other ministries
- Include marginalized populations
- Increase understanding of services and how the public can access them

Overview of Action Plans

1) **Development of a comprehensive chronic disease prevention and management approach to service delivery across the continuum of care.**

2) **Development and dissemination of integrated, comprehensive care pathways for specific chronic disease issues.**

4.2.5 Integrating Mental Health and Addictions Services[27]

Recovery does not mean complete cure – it is a process which individuals work through over time, which can be achieved through many different paths and approaches.[31]

Description

This priority addresses the challenges facing people living with mental illness and/or addictions and their families within the Mississauga Halton LHIN through a multi-faceted approach.

The Toronto-Peel Mental Health Implementation Task Force ("MHITF"), Central South MHITF, Centre for Addiction and Mental Health ("CAMH") and the Ontario Mental Health Implementation Task Force have formulated best practices, service delivery and policy in the development of a Mental Health and Addictions Recovery model. Recovery[28] is defined by the individual, not by the provider. A recovery-based model would be driven by the principles outlined below[29].

Placing individuals with mental illness and their families at the centre of the system[30]

- Tailoring a comprehensive range of services and supports to consumer needs to increase quality of life[31]

- **Focusing on streamlining access**[32]
  - Improving consumer choice and access to services[33]
  - Linking and coordinating services so that consumers will move easily from one part of the system to another[34]
- **Creating greater accountability**[35]
  - Basing services on best practices[36]
  - Continue to protect mental health funding[37]

Stigma associated with individuals with mental illness and addictions[38] causes many patients to be labeled as 'hard to serve' or 'uncooperative'. Stigma and discrimination create barriers to recovery.[39]

Pockets of exemplary service exist across the LHIN, but this is not the norm. The current system is fragmented. Individuals living with mental illness and/or addictions, their families and support networks have difficulty gaining access to a range of services tailored to their needs. This is especially true for individuals with concurrent disorders or dual diagnoses. Improving accessibility to services will help foster choice, allow individuals to reside in their own homes and enable an individual's independence in making life decisions.

[27] Refer to Appendix G.5 for the full details of this Priority.
[28] The Time Has Come: Make It Happen. Toronto-Peel Mental Health Implementation Task Force. 2002.
[29] Ibid
[30] The Time is Now: Themes and Recommendations for Mental Health Reform in Ontario. Final Report of the Provincial Forum of Mental Health Implementation Task Force Chairs. 2002.
[31] Making it Happen: Operational Framework for the Delivery of Mental Health Services and Supports. Ontario Ministry of Health. 1999.
[32] The Time is Now: Themes and Recommendations for Mental Health Reform in Ontario. Final Report of the Provincial Forum of Mental Health Implementation Task Force Chairs. 2002.
[33] Ibid
[34] Making it Happen: Operational Framework for the Delivery of Mental Health Services and Supports. Ontario Ministry of Health. 1999.
[35] The Time is Now: Themes and Recommendations for Mental Health Reform in Ontario. Final Report of the Provincial Forum of Mental Health Implementation Task Force Chairs. 2002.
[36] Making it Happen: Operational Framework for the Delivery of Mental Health Services and Supports. Ontario Ministry of Health. 1999.
[37] Ibid
[38] Refer to Appendix G.5: Integrating Mental Health Services for the definition of Stigma
[39] The World Health Organization's World Health Report 2001

What will success look like?

To meet the needs of this population a truly integrated approach to service delivery across the continuum of care – promotive, preventive, curative, rehabilitative and supportive – and a new level of coordination and connectivity is required.

An integrated continuum of care for mental health and addictions services will be designed on best practices currently in existence within the Mississauga Halton LHIN and best practices from other jurisdictions. A broad based Cross-sectoral group is needed to support the development of this integrated model.

"Let's first figure out what the system should look like."

Karen McGrath
CEO, Canadian Mental Health Association, Ontario

Environmental Scan

- The community mental health and addictions sectors has seen little or no change in terms of investment and restructuring despite major reform initiatives in both sectors. As a result, these sectors remain fragmented, undersized and difficult to access.[40]
- Only about half of the organizations surveyed indicated any collaborative relationships existed between providers and those that existed were most often between "like" services (e.g., hospital to hospital; mental health agency to mental health agency). This suggests there is a need and opportunity to develop a more integrated service delivery model for children and youth for the residents of the Mississauga Halton LHIN.

Community Engagement

A sample of what we heard:

- Ensure central access to services - 'no wrong door' concept
- Implement integrated approach across services
- Increase access to services by family doctors for their patients
- Emergency departments are not well equipped to deal with individuals suffering with addictions or mental illness
- Enhance discharge planning and post discharge follow-up
- Bridge both the youth and seniors transition gaps by providing learning/training activities
- Expand concurrent disorder supports

"There's no health without mental health."

Karen McGrath
CEO, Canadian Mental Health Association, Ontario

[40] Halton-Peel District Health Council Operating Plan – September 15, 2004

Overview of Action Plans

1) **Develop an integrated approach to service delivery across the continuum and life cycle which builds on current initiatives and previous studies.**

2) **Focus on an early win approach which leverages current partnerships and concentrates on the development of new ones to enhance coordination.**

4.3 Enabling Strategies

The following seven enabling strategies are fundamental to achieving success across all the priorities and will be used by Detailed Planning and Action Teams to develop priority action plans and recommendations as they work towards achieving integration goals.

4.3.1 Information and Technology Solutions

The IHSP and the priorities for integration will drive the LHIN's information and technology agenda. Integration is dependent on cross provider, cross sectoral information sharing in the mid to long term. Coordinated data management ensures efficient decision-making for better health outcomes. Technology solutions also help consumers navigate the health system and manage the complexity of living with long-term illness.

4.3.2 Health Human Resources Planning

A strategic health human resources plan that considers population growth, changing demographics and addresses the unique cultural, spiritual and language needs of the Mississauga Halton LHIN will form the basis of current and future human resource policy.

4.3.3 Health Promotion and Disease Prevention

By increasing public accountability for optimizing their personal health, it will encourage the adoption of healthy lifestyles which maintain good health. The provision of health and wellness education and materials will help support informed decision making. Providers have a responsibility to disseminate information and champion informed public choice in the maintenance of good health.

4.3.4 Education and Knowledge Sharing

Knowledge sharing promotes the dissemination of new information to ensure greater awareness of evidence-based practices. It provides professional development opportunities to maximize scope of practice and allows for greater understanding of best practices. It is through the application of best practice through knowledge transfer which results in behaviour change in service delivery that will have a direct impact on health outcomes.

4.3.5 Transportation

Challenges associated with transportation have a significant impact on access to services and non-urgent medical transportation is a highly effective aspect of preventive health care. Accessing services before patient needs become urgent was identified in both rural and urban parts of the LHIN as a transportation issue. A solution that considers the unique challenges of north-south and east-west transportation should be reviewed at multiple levels and in cooperation with government partners.

4.3.6 Ease of Movement Through the System

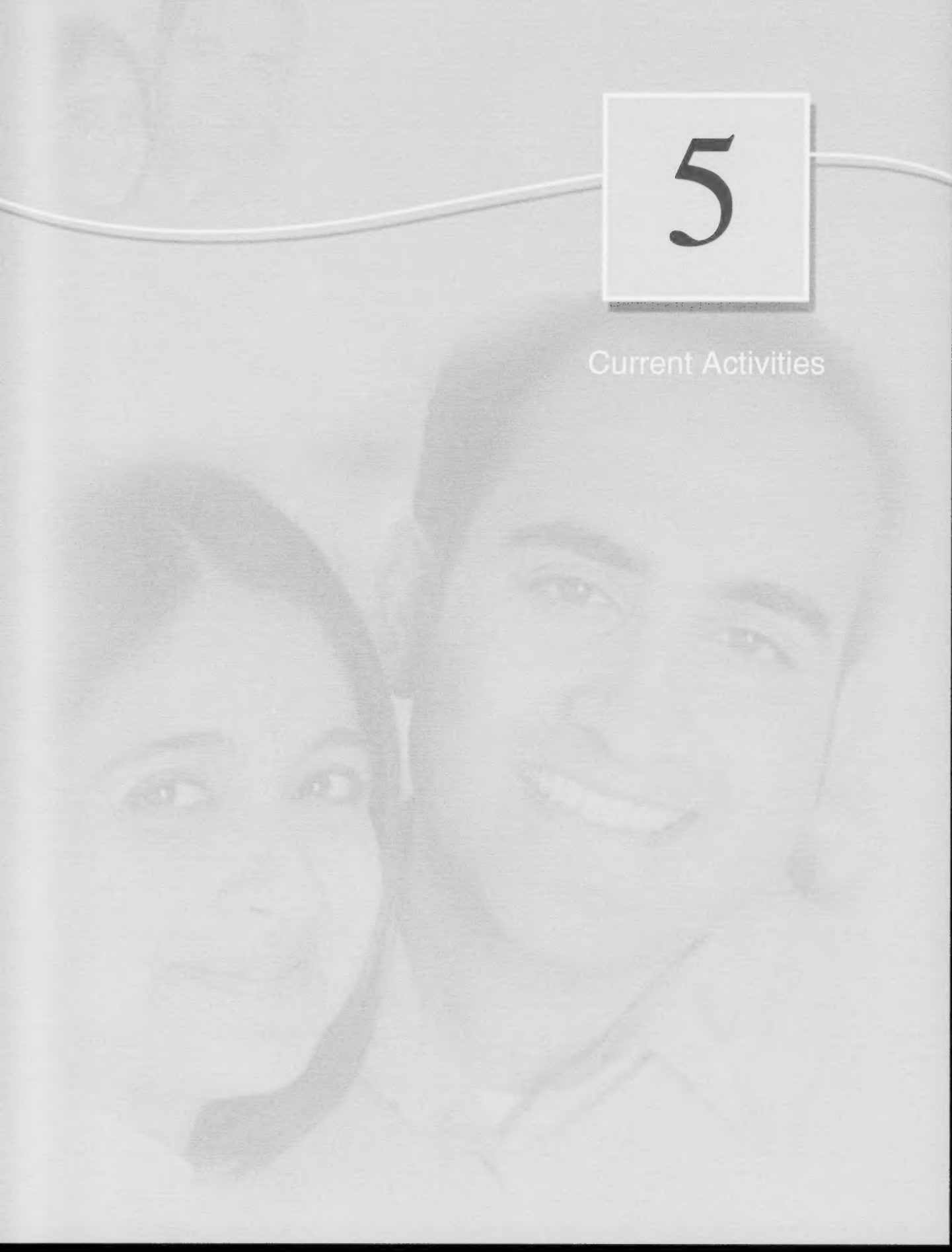
Integrating health care services throughout the LHIN should enable patients to access services easily and move seamlessly from point to point throughout their entire care experience. Residents need to know what services are available, how to access them and where they are available. Individuals with complex needs will benefit from the development of an enhanced care coordination role, under the guidance of a care coordinator, to improve care management and access.

4.3.7 Best Practice Care Maps and Standardization

The development of best practice care maps and standardization will help to promote collaboration, education and general awareness among providers. Standardized care maps ensure quality and equity across the system and will be developed from the sharing of information across providers, research and evaluation of existing models.

5

Current Activities



The Mississauga Halton LHIN is committed to building an integrated and coordinated system with the full and continuous involvement of key partners, health service providers and the public to support local health system planning and design.

5 Current Activities

The Mississauga Halton LHIN has made steady progress towards cultivating a strong foundation of strategic partnerships, connecting to our communities by listening to ideas and concerns and discussing solutions to achieve our future goals.

5.1 Summary of Achievements to Date

Our primary objectives have focused on:

- Establishing LHIN governance policies and practices.
- Developing strategic relationships.
- Developing and implementing a community engagement plan and creating an Integrated Health Service Plan (IHSP).
- Recruiting staff.
- Developing and implementing business processes.

5.2 Key Initiatives

Networks – There are many well-established networks in Mississauga Halton that are effectively responding to local community needs and finding innovative ways to act on integration opportunities to achieve their goals. These networks are an essential source of expertise for planning and coordination of services and have valuable experience integrating across traditional boundaries of health sectors, organizations and geographies.

Engaging Local Networks – All networks within the Mississauga Halton LHIN were surveyed about their current integration initiatives. These initiatives were compared to local priorities and results were incorporated into the storybooks for each priority[41]. The Mississauga Halton LHIN will continue to engage existing local networks and develop new ones, as required.

Enhancing Critical Care Capacity – In collaboration and with the full support of all the hospitals in the area, Dr. Lawrence Chau from Halton Healthcare Services was selected as the critical care lead. Dr. Chau will be involved in provincial critical care planning to ensure local critical care capacity meets provincial best practice standards. Dr. Chau reports to the Mississauga Halton LHIN CEO and the Assistant Deputy Minister for Health System Accountability and Performance.

[41] Refer to Appendix G for additional detail.

Expanding the Implementation of Back Office – Shared Services West (SSW) was established in January 2001 and is owned and operated under the guidance of local hospitals, including the Credit Valley Hospital, Halton Healthcare Services, Trillium Health Centre and William Osler Health Centre. The mandate of Shared Services West is to seek out and implement opportunities for Increasing the effectiveness and efficiency of providing "Back Office" functions. "Back Office" functions such as accounting, personnel, purchasing, materials management and computer systems typically support, but are not directly involved in the operations of an organization. Preliminary discussions with the leadership of SSW, to expand contracts to other providers in the Mississauga Halton LHIN, are underway in order to capitalize on cost savings for providers.

Immediate opportunities include:

- Supply Chain management
- Equipment – computers, printers, photo copiers etc.
- Ontario buys
- Medical supplies
- E-commerce
- Benefits Administration – consulting and advisory services
- Non-urgent patient transportation

5.3 Initiatives We Can Leverage

Regional Geriatric Program – Under the leadership of Dr. Barbara Clive, a geriatrician from the Credit Valley Hospital and Ray Applebaum, CEO of Peel Senior Link, a group of providers interested in the care of the elderly has been formed to consider a LHIN-wide approach to integrated care for the seniors. Considerable collaborative work has occurred to develop a plan to integrate care for seniors in our area. LHIN leadership has met with this group to discuss progress as well as offer encouragement and advice. Demographic trends of a growing, aging population reinforce the immediate and future necessity for a coordinated geriatric program.

Primary Health Care / Family Practice Physicians – Issues facing primary health care and family practice physicians are also a key focus for our LHIN. The Mississauga Halton – Central West Community Family Medicine / Public Health Network is a local physician network that is expanding its membership and mandate. Medical Officers of Health and community physicians are also a part of this group to ensure close working relationships across all sectors. One of the strategic initiatives of this network is to build on the knowledge gained through the National Home Care and Primary Health Care partnership project. The Mississauga Halton LHIN has developed an effective relationship and provides support to this important group of physicians.

Family Medicine Teaching Unit – A unit will be established at Credit Valley Hospital and it is part of the Academy of Medicine of the University of Toronto, Mississauga campus. The Trillium Health Centre is also considering a family medicine teaching unit. Future graduates of this program will gain inter-disciplinary experience within the community which may encourage them to stay and practice within our LHIN. While the establishment of the unit is an important development within the LHIN, developing teaching programs within a community hospital have real implications on space as well as operating costs. In order for the program to be successful, it will be essential that additional space requirements are addressed and that any additional operating resources are reflected within the hospital's operating budget.

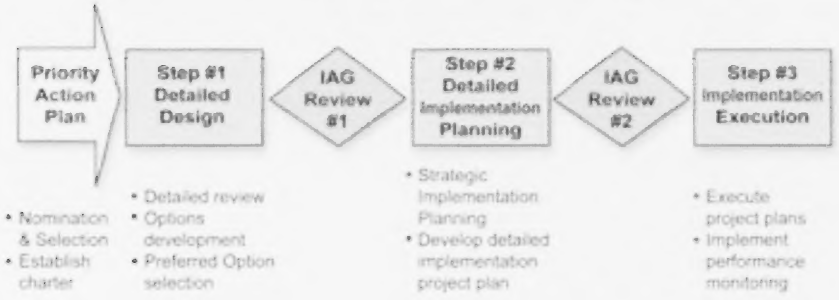
5.4 Going Forward

Engaging the public and providers in health service planning and detailed design will result in:

- A local health system that has increased "buy-in".
- Achievement of appropriate outcomes.
- Support for more informed decisions regarding service provision and delivery.
- Innovative solutions to community issues that is more holistic and creative.
- The improved health of populations and satisfaction with the system.

Post IHSP: Detailed Design and Action Planning Process
The Mississauga Halton LHIN will nominate and select individuals to participate on one of the numerous Detailed Planning and Action teams (DPA teams). Each DPA team will develop a detailed review of their action plan to provide options for next steps.

Figure 12: Detailed Design and Action Planning Process



How the Public Could Support Success

Public participants engaged in Phase Two of our community engagement process offered the following ideas for consumer roles or activities to keep residents involved.

- Participate on Detailed Planning and Action teams (DPA teams).
- Continue involvement in all community engagement activities.
- Talk to friends and family about what was heard.
- Cultural and Faith communities need greater awareness of how to support their own members in the community.
- Continue to advocate for the small/less popular populations/ programs.
- Address information gaps identified by the community.
- Empower the community to take responsibility for their own health.

Integration Advisory Group

An Integration Advisory Group (IAG) consisting of local leaders with health sector expertise was formed in the Mississauga Halton LHIN. The IAG provided advice and made final recommendations on the IHSP to the LHIN's Board of Directors[42].

On an ongoing basis, the IAG will provide strategic leadership, ensure that all DPA teams within each local priority area bring forward integration opportunities aligned with local needs, provide support for DPA team member nominations and oversee and review all recommendations and options from the DPA teams before presenting recommendations to the Board.

How Health Service Providers and Other Key Partners Could Support Success

Health service providers and other key partners have a fundamental responsibility in developing and implementing an integrated health system. Providers and partners were involved in all of our community engagement activities and the following roles were identified:

- Participate on DPA teams and any leadership groups (such as IAG).
- Build a strong volunteer base.
- Remain critical and to challenge the status quo.
- Be present and involved with an open mind.
- Remain focused on the client at all times.
- Deliver the message to our community; community partnerships.

[42] Refer to Appendix F for additional detail.

- Commit to the vision and make it work.
- Work together.
- Advocate and educate for one system.
- Implement action plans as they roll out.

The Mississauga Halton LHIN is committed to building an integrated and coordinated system with the full and continuous involvement of key partners, health service providers and the public to support local health system planning and design.

Part 6 outlines specific goals, strategies and action items that will be addressed by the DPA teams and the IAG.

6

Action Plans for Integration Priorities

Collecting data, conducting community engagement, analyzing findings and planning strategic directions are good first steps, but will not change the health system. It is the execution of strategy into action that will help us succeed in transforming the health system.

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6.1 Improving Health System Performance Action Plans[43]

Action Plan #1: Strengthen coordination and integration across providers to improve client/patient access and movement across the continuum.

I will be able to easily get the health care services that I need from the health service provider that I should see in a timely manner.

Improved access and movement through the system are critical to success, for the public, providers and the Mississauga Halton LHIN and a disciplined approach to improved coordination across the networks is required. We will establish a Rapid Action Team to complete the following:

- Review the best practices in idea management process development;
- Develop an innovative integration idea management process including the following components:
  - Integration idea submission form
  - Integration idea scorecard
  - Integration idea management process (visual)
- Communication plan and materials to announce the Mississauga Halton LHIN innovative integration idea process.

We will also establish a Detailed Planning and Action (DPA) team to complete the following:

- Develop a total service inventory by coordinating the inputs of the three other DPA teams to ensure there is no duplication of effort.
- Conduct a detailed review to identify population driven needs to address the local differences across the network.
- All of the Priority DPA teams will supply this team with information in a coordinated manner to enable horizontal and vertical analysis of all data.

[43] Refer to Appendix G.1 for the full details of this Priority.

Action Plan #2: In partnership with providers across the LHIN, develop innovative local solutions to provincial priorities.

The focus of this plan is to work in cooperation with providers across the LHIN to develop innovative local solutions to achieve established targets or improve on those targets.

We will establish a Detailed Planning and Action (DPA) team to complete the following:

- Identify appropriate planning opportunities for achieving provincial priorities utilizing optimal local system-wide strategies.
- Further enhance planning across the LHIN, share environmental scan data with providers to enable planning at the local level.

My wait times will be shorter throughout the Mississauga Halton LHIN for those services that are publicly reported.

6.2 Strengthening Primary Health Care Action Plans[44]

Action Plan #1: Strengthen inter-disciplinary collaboration across providers through improving communication and linkages among physicians and primary health care providers and partners.

To successfully improve inter-disciplinary practice, regardless of the physician practice model, by improving communication and linkages between physicians, their patients, specialists, and other health care providers across sectors will require a concerted effort and significant leadership for successful transformation.

We will create Detailed Planning and Action (DPA) teams to focus on specific aspects of information sharing and partnership including the following:

- Build on the success of the National Home Care and Primary Health Care Partnership Project by expanding case manager services available to family physicians, hospitals and other health service providers.
- Improve access to patient information including:
  - Creating a traveling patient record accessible to all health professionals;
  - Ensuring physicians have access to patient records in all hospitals within the Mississauga Halton LHIN (and in neighbouring LHINs if possible); and
  - Improving communication across hospitals and physicians and community sector organizations at the point of discharge

I will interact with the right health service providers to ensure my health care needs are met.

[44] Refer to Appendix G.2 for the full details of this priority.

- Create improved coordination and communication between specialists and family physicians.
- Improve equitable access to rapid diagnostics and results.
- Improve the knowledge and understanding (by patients and health service providers) of services available in the Mississauga Halton LHIN.

Action Plan #2: Improve and strengthen support programs available for expectant mothers, new mothers and newborns.

As a new mom I will receive the care and services that I require both before and after delivering my baby.

Community engagement forums revealed that unmet needs exist for post-partum follow-up visits with new mothers and babies. There were 11,950 newborns in Mississauga Halton hospitals in 2004-2005. Birth rates between 1997 and 2003 have remained relatively steady for Mississauga Halton women and match provincial rates. Opportunities exist for improving the supports and education materials for new mothers and newborns and adopting successful efforts from local sites of larger networks such as the West Cluster Child Health Care Network.

We need to:

- Develop an inventory of the current scope of services and activity.
- Determine the unmet needs through consultations with new mothers.
- Develop and implement recommendations and plan of action to better meet the needs of this population (e.g., additional home visits, clinics and printed materials).

Action Plan #3: Enhance inter-disciplinary service delivery and service availability to children and youth to better meet the needs of this population throughout the LHIN.

If my child is developmentally delayed, he will be diagnosed at the earliest possible time.

Currently children and youth represent approximately 26% of the population. Community engagement forums revealed significant challenges in accessing services, if services exist at all. Short-term actions will focus on developing a baseline inventory of current services, develop greater understanding of this population's needs in detail at the sub-LHIN level and identify service gaps.

We need to:

- Develop an inventory of the current scope of services and activity.
- Determine the unmet needs through community engagement.
- Identify the appropriate basket of services for all levels of service.
- Develop and implement recommendations and plan of action to better meet the needs of this population.

6.3 Enhancing Seniors' Health, Wellness and Quality of Life Action Plans[45]

Action Plan #1: Implement the integrated service delivery model for seniors.

A new integrated service delivery model for seniors requires organizations to work together in different ways, and the implementation of the following critical success factors:

- Recruit a Coordinator of Integrated Services for Seniors to oversee and manage transformation from the current state to the integrated model.
- Establish a joint accountability structure with two tiers -- a "Coordinating Council" and a "Project Steering Committee".
- Form two Detailed Planning and Action teams to confirm the geographic regions and determine the prioritized list of the scope of services through a detailed approach to community engagement and data analysis.
- Create a series of detailed planning and action teams to focus on specific aspects of the model (e.g. assessment tool, prioritized list of the scope of services, information management, etc).
- Identify "early wins" and/or pilot project opportunities (e.g. focus on falls prevention).

The integrated service delivery model has wide community support. It embraces the vision of health for Ontario and holds the potential to benefit seniors, their families and the health system as a whole for years to come.

Action Plan #2: Enhance the role of long-term care homes.

An effective integrated health system facilitates the delivery of care to people in the most appropriate setting for their needs. Long-term care (LTC) homes play a unique role in the health system for seniors (and others) who are no longer able to live independently in their own home. With the aging of the population and an increase in community-based options available to seniors, the average age and the acuity level in long term care homes are both rising. Long-term care providers report challenges in responding to the complex needs of residents such as those with mental health and/or addictions issues, behavioural issues and poly-pharmacy.

In 2004/05, Mississauga Halton LHIN had 4,157 long-term care beds in its 27 long-term care homes. Long-term care homes interface with many other parts of the health system. A number of collaborative initiatives

As my health care needs change I will have access to a seamless continuum of services through one entry point.

As an individual, 55 or older, I will get reminders for my check-up and receive the appropriate follow-up and education.

As a resident of a long-term care home, I will have the supports I need to stay in my home.

[45] Refer to Appendix G.3 for the full details of this Priority.

I will be able to live at home independently and with the proper supports for as long as possible.

Are already underway in the LHIN to create partnerships aimed at improving service delivery in the long-term care sector. Refer to Appendix G.3 for further details.

Opportunities exist to further enhance the role that long term care homes can play in an integrated system by strengthening linkages with other sectors and by improving the capacity of long-term care homes to meet the complex needs of their residents.

We need to:

- Increase the use of nurse practitioners in long-term care homes.
- Develop designated units in long-term care homes for residents with behavioural issues.
- Enhance clinical expertise available in long-term care homes to assist in reducing unnecessary emergency department visits i.e. Nurse Practitioners, or hospital expertise to assist long-term care homes, education initiatives.
- Use long-term care homes to reduce reliance on Complex Continuing Care (CCC) beds and ALC utilization.

Action Plan #3: Build on the End-of-Life Strategy to develop a comprehensive approach for Palliative Care.

When someone in my family is nearing the end of life, we will have options and the supports we need.

As part of the continuum of care, an integrated approach to palliative care is imperative, to ensure patient choice and integrity to the end. "End of life" Care Is a provincial priority and a strategy is in place to increase focus and Investment in this area. Mississauga Halton is well positioned to move forward quickly with the development of enhanced palliative care teams because there are a number of resources upon which to build, including: an active Halton Peel Palliative Care Network; several hospices (both community-based and free-standing); a Regional Cancer Centre at Credit Valley Hospital and palliative care expertise in hospitals, CCACs and home care agencies.

We need to:

- Integrate inter-disciplinary palliative care resource teams.
- Establish more palliative care teams.

Although this integration opportunity is positioned within the Seniors priority area, the palliative care needs of all lifecycle population groups (e.g. children, younger adults) will be recognized in the design and delivery of this service.

6.4 Preventing and Managing Long-Lasting (Chronic) Conditions Action Plans[46]

I will be able to get the services and information that I need to be able to manage my chronic condition(s).

Action Plan #1: Development of a comprehensive chronic disease prevention and management approach to service delivery across the continuum of care.

Research has shown that effective chronic disease prevention and management (CDPM) programs use multiple strategies and interventions and promote Collaboration among providers, organizations, individuals, families and community groups. Individuals with chronic diseases often require a range of services and with the aging of the population the number of individuals with multiple chronic diseases will increase. Therefore, CDPM must involve the full continuum of care. Rehabilitation to maximize functional levels is an important component of the continuum of care required for effective chronic disease prevention and management. This provides an opportunity to review the roles of providers in terms of chronic disease, review the various settings in which patients receive treatment and support for chronic disease and build on several evidence-based models and resources from other jurisdictions.

We need to:

- Identify a generic CDPM model that can be applied to a range of different chronic diseases.
- Ensure the delivery of services in the most appropriate setting which might mean shifting certain ambulatory services from the hospital sector to the community.
- Build on existing evidence-based initiatives in Mississauga Halton LHIN and in other jurisdictions.

The services that I need to manage my diabetes will be consistent and available close to home.

Action Plan #2: Development and dissemination of integrated, comprehensive care pathways for specific chronic disease issues.

Integrated, comprehensive care pathways provide a standardized approach to the management of chronic diseases. Pathways can be developed to include multiple disciplines and service delivery settings. They are based on evidence-based clinical guidelines.

As a result we need to:

- Establish an Integrated Care Pathways Action Team (this could be a sub-Planning and Action team that reports to the CDPM Detailed Planning and Action team).
- Assess the current situation.
- Prepare plans to develop or adopt integrated, comprehensive care pathways for specific chronic diseases.

[46] Refer to Appendix G.4 for the full details of this Priority

I will be able to easily access the services that I need and will be referred to other services as required.

If I am in the hospital, I know that upon discharge, I will be connected to the community services that I need.

My child will be referred by our family physician to mental health or addictions services that are appropriate for her age and needs.

6.5 Integrating Mental Health and Addictions Services Action Plans[47]

Action Plan #1: Develop an integrated approach to service delivery across the continuum and life cycle, which builds on current initiatives and previous studies.

Local care delivery systems focus on providing services within the community and are built upon current and new partnerships to enhance coordination across the full continuum, including:

- A local care delivery system, which focuses on providing a comprehensive service continuum, is based on client needs and best practices. Mental health services levels of care (first-line, intensive and specialized) and supports (e.g. housing, vocational, social-recreational supports) will be coordinated and integrated.
- Many opportunities to create system improvements in the first level.
- Creating linkages within the different levels of care.
- Sharing responsibility and accountability among service providers is required to ensure the roles and responsibilities of providers is clear and delivered services are effective, efficient, seamless, responsive and accountable.[48]
- Addressing recommendations for specific populations, including age specific and cultural needs.

Integration needs to embrace a multi-faceted approach by incorporating greater coordination in the following areas:

- Within and across mental health services and providers;
- Within and across addiction services and providers;
- Across mental health and addiction services and providers;
- Across mental health and addition services and the health care system; and
- Across mental health and addition services and key partners of the health care system.

Action Plan #2: Focus on an early win approach which leverages current partnerships and concentrates on the development of new ones to enhance coordination.

The ability to leverage existing examples of exemplary service must align with the vision, strategic goals and guiding principles for mental health and addiction services across the Mississauga Halton LHIN.

[47] Refer to Appendix G.5 for the full details of this Priority.
[48] The Time Has Come: Make It Happen. Toronto-Peel Mental Health Implementation Task Force. 2002

Our mandate will focus on those areas that can leverage current capability across the Mississauga Halton LHIN and deliver improvements for both the public and providers in the short to mid term. The Mental Health and Addiction Rapid Action Teams will collaborate with the Mental Health and Addiction Detailed Planning and Action Team to ensure coordination with the long-term vision.

As a result we need to:

- Establish a mental health and addictions Rapid Action Team.
- Identify opportunities to enhance coordination.

If I need to visit an Emergency Department for a crisis in the middle of the night, care will be provided by the right person in a timely manner.

6.6 Challenges that Could Impact Successful Implementation

We gained considerable insight from our dialogue with both the public and providers about the challenges that need to be considered during the implementation of our strategic directions.

These challenges include:

- **Transportation:** Rural and urban settings both identified non-urgent transport as a significant barrier to equitable access to services.
- **Culturally Sensitive Service Delivery:** To increase cultural awareness and sensitivity in delivery of service requires significant learning and development to meet the needs of our current and future population.
- **Health Human Resources:** The best developed plans will not be successful unless the right set of health human resources is available to execute.
- **Funding:** Concern was voiced regarding current funding allocations for Mississauga Halton health services in comparison to the provincial average and other LHINs and in light of current and future population growth projections.
- **Access:** Wait times for services beyond those tracked by the wait time strategy were identified beginning with access to family physicians, specialists, other health services through to specialized tertiary care services.
- **Organizational and Behavioural Change is Needed:** The vision presented within this document is not about tweaking the system, but about innovative and new ways of working. Implementation must execute strategies to effectively manage the scope of change successfully.

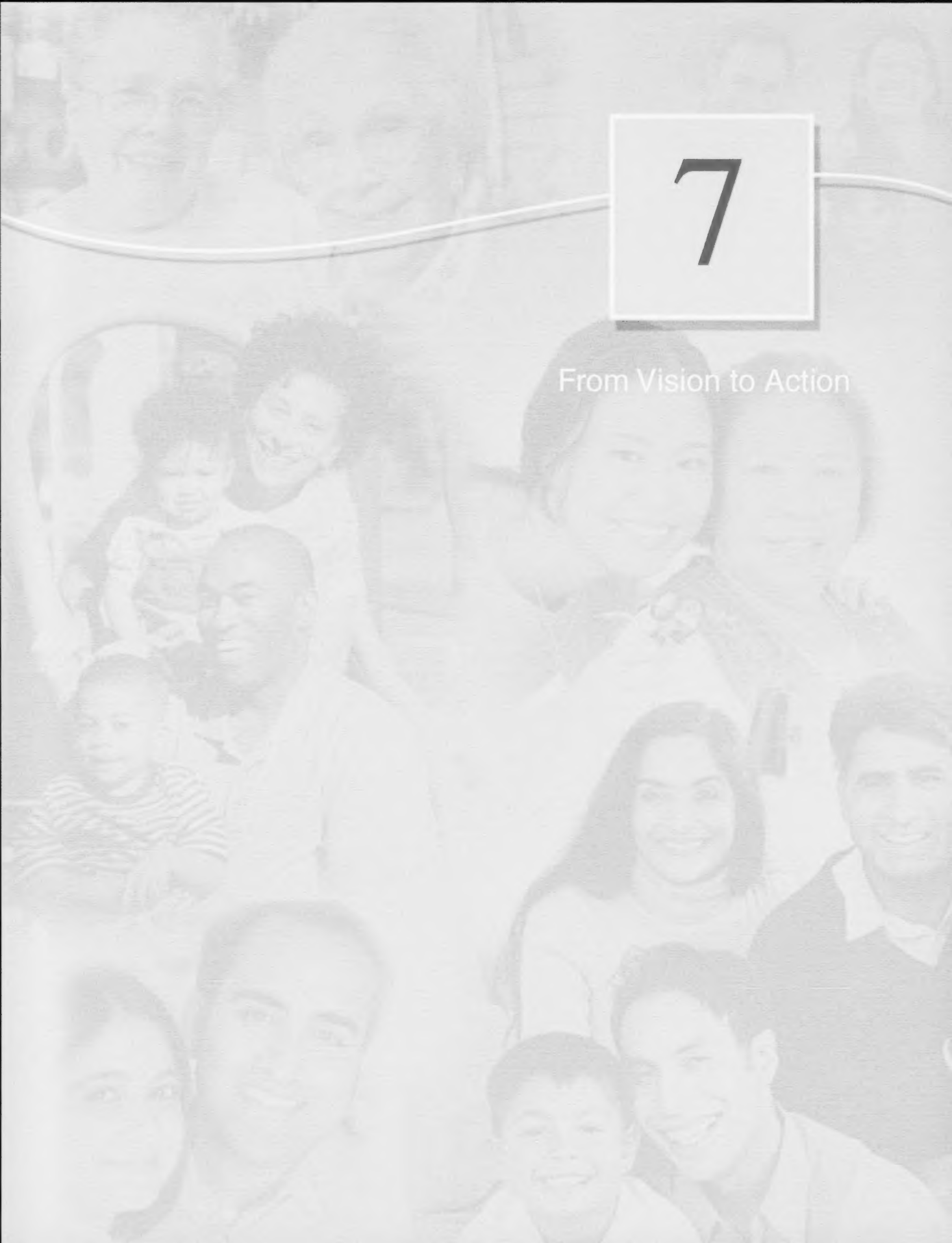
"We need to not only start thinking outside the box, but we need to build new boxes."

Dr. Andrew Pipe
Physician and Director of
The Minto Prevention &
Rehabilitation Centre, Ottawa

- **Information Management:** Public and providers alike cautioned that an electronically connected system is necessary to realize our vision.
- **Cross Ministry / Cross Government Partnerships/ Cross Funder:** Our mandate as a LHIN requires an innovative, systems approach to planning regardless of the accountability for funding. Joint accountability for outcomes across ministries and levels of government will require new ways of working together in a meaningful and a fully participatory manner.

7

From Vision to Action



A strong and compelling shared vision of an integrated health system is at the heart of both provincial and Mississauga Halton LHIN efforts to transform local health services into a seamless system that benefits local residents.

7 From Vision to Action

A strong and compelling shared vision of an integrated health system is at the heart of both provincial and Mississauga Halton LHIN efforts to transform local health services into a seamless system that benefits local residents.

The integration priorities and action plans outlined in this document represent the consensus of our local Mississauga Halton initiatives for change. The plan has been developed through a broad consultation process that involved literally many thousands of people. Input from the public and providers was remarkably congruent and helped us evolve and improve our plan.

The IHSP is strategic in nature. It outlines a road map for action that the Mississauga Halton LHIN, together with local health service providers, will work on over the next three years. Engaging our communities in an ongoing way will continue as detailed design and implementation begins on each of the action plans. Following approval of the IHSP, Detailed Planning and Action Teams (DPA Teams) will be formed with representation from across our LHIN, other ministries and the broader community.

"Vision without action is a dream.
Action without vision is simply passing the time.
Action with vision is making a positive difference."

Joel Barker

Mississauga Halton LHIN

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